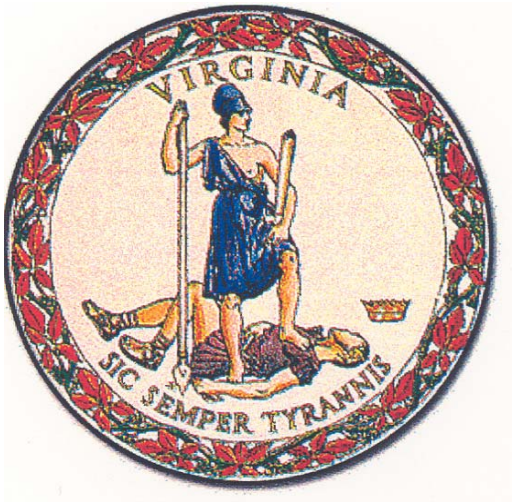

Review of the Recovery Experience of Individuals Served at Mental Health Facilities Operated by DMHMRSAS

Office of the Inspector General
For Mental Health, Mental Retardation
& Substance Abuse Services

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Inspector General

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Office of the Inspector General

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Section I

Office of the Inspector General

Review of the Recovery Experience of Individuals Served at Mental Health Facilities Operated by DMHRSAS

Executive Summary

The Office of the Inspector General for Mental Health, Mental Retardation & Substance Abuse Services (OIG) has conducted a review of the eight state hospitals that serve adults to assess the recovery experience of persons who are served at these facilities. This project was selected in response to recent action by the Department of Mental Health, Mental Retardation & Substance Abuse Services (DMHMRSAS) to establish the following goal:

> *Fully implement self-determination, empowerment, recovery, resilience, and person-centered core values at all levels of the system through policy and practices that reflect the unique circumstances of individuals receiving MH, MR and SA services.*

The series of inspections that was carried out from December 2006 to February 2007, examines the extent to which the experience of individuals in our state hospitals reflects the principles of recovery, self-determination, and participation. The results of this project capture the starting point for this important DMHMRSAS initiative in the state hospitals and will provide a baseline against which future progress can be measured.

Input to the design of the review was sought from a wide range of stakeholders with particular attention to contributions made by current and former service recipients. The SAMSHA National Consensus Statement on Mental Health Recovery was selected as the definition of recovery and basis for indicators of quality in this review. The OIG inspection team included three individuals who have previously utilized the services of the Virginia public mental heath system.

This project included announced visits to each hospital, unannounced observations of treatment teams, and a follow-up survey. During the facility visits: 309 service recipients were interviewed (21% of total census); clinical records for the same 309 individuals were reviewed; observations were conducted in 100% (70) of the residential units and 91 of the psychosocial rehabilitation (PSR) classes; and treatment team sessions were observed for 40 individuals. A total of 582 staff were interviewed as well as the executive team for each hospital.

Through the interviews of service recipients and reviews of clinical records, both of which were specific to individuals, the OIG made a determination of the percentage of persons in the state hospitals whose experience reflects the principles of recovery, self-determination and participation. Three separate ratings related to the recovery experience

were calculated for the observations that were made in the residential units, PSR classes, and treatment team meetings. All of these scores are available in the body of the report. In addition, the OIG made the following findings and recommendations:

Findings

Treatment Planning through Partnership

Finding 1: A significant number of persons served in state mental health facilities report that they do not have sufficient input to or influence on the development and documentation of their own goals and treatment plans.

Finding 2: Residential and PSR staff, family members, friends, and advocates who can assist and support the individual during treatment team meetings are generally not present at these meetings.

Finding 3: Representatives from the community who hold a key role in connecting the resident to his home community and planning for discharge are generally not present at treatment team meetings.

Finding 4: Treatment team discussions focus primarily on symptoms, behaviors, and medication issues in the hospital – failing to focus on the whole person, the full treatment/psychosocial experience and the individual's own goals. The individual's treatment plan is generally not central to the treatment team discussion.

Finding 5: The leadership provided by the team leader, who is most often a psychiatrist, is found to be the dominant variable in the degree to which the treatment team meetings reflect recovery values. This leadership varies greatly among the facilities and treatment teams.

Finding 6: Record systems reflect a traditional, deficit-based approach to treatment planning and documentation. The record format neither encourages nor facilitates person-centered, person-directed treatment planning. When found at all, which was rare, a person's own concept of goals and plans are an addendum, rather than the central core of the treatment plan.

Finding 7: While every hospital provides some consumer feedback opportunities, few were judged to be comprehensive or to give residents a regular, timely opportunity to provide feedback about their satisfaction with treatment and conditions at the hospital.

Choice

Finding 8: Choice, an essential empowering opportunity for persons on the road to recovery, is limited and restricted for the residents in Virginia's state mental health facilities.

Finding 9: The system for granting "privilege levels", a major determinant of the residents' freedom and choice, varies among and even within the mental health hospitals. These systems are often not clearly understood by residents and staff.

Involvement in Valued Roles

Finding 10: Little use of peers to provide support groups, mentoring, or other opportunities to perform valued roles are found in the residential units and PSR classes.

Finding 11: The numbers of individuals who have completed WRAP training and the numbers who have completed personal WRAP plans are very low at the mental health facilities.

Finding 12: Employment and meaningful volunteer opportunities on the facility campus vary significantly across the eight facilities and are very low at some facilities.

Finding 13: Employment and volunteer involvement in the community are quite low.

Relationships that Support Recovery

Finding 14: A high percentage of individuals report that there is someone they can trust, relate to and count on at the facility.

Finding 15: Facilities do not emphasize or foster the development of supportive connections and helping relationships through programming and treatment.

Finding 16: Residents report that staff members convey that they have hope for recovery of those they serve.

Finding 17: Major gaps exist in staff knowledge and attitudes about recovery-based treatment.

Finding 18: There are indications from residents that staff may not value or be adequately respectful of their opinions and perspectives.

Finding 19: "Person first" language is not consistently used by staff.

Providing a Supportive Environment for Recovery

Finding 20: Staff interactions with residents in PSR classes are generally positive and appropriate.

Finding 21: Staff interactions with residents in the residential units are inconsistent across the eight hospitals, but most often inadequate to foster a recovery environment in activities of daily living, leisure time use, and stimulation of interests.

Finding 22: Most residential units lack supplies, resources and activities to enable residents to develop and engage in interests, learn about recovery, pass time productively and avoid boredom.

Finding 23: The physical environment of many residential unit common spaces, bedrooms and bathrooms lack warmth, comfort, attractiveness and privacy.

Finding 24: A significant number of individuals in the mental health hospitals say that they do not feel safe in the facility. This factor greatly limits the individual's progress in recovery.

Recommendations

Recommendation 1: It is recommended that each mental health facility develop and implement a Comprehensive Facility Plan on Recovery. The purpose of this plan will be to enhance the extent to which the experience of those individuals who are served reflects the principles of recovery, self-determination, person-centered planning, and choice. The plan should identify specific measures that will be used to assess progress, be completed no later than August 30, 2007, and address:

- The role of senior leadership
- Workforce development
- Treatment planning
- Design of the clinical record
- Resident activities and opportunities
- Relationship to the community
- Other areas as determined relevant to enhancing the recovery experience of those who are served by the facility.

DMHMRSAS Response: *DMHMRSAS accepts the recommendation of the Inspector General. The Assistant Commissioner for Facility Management will have each mental health facility develop and implement a Comprehensive Facility Plan on Recovery. The purpose of this plan will be to enhance the extent to which the experience of those individuals who are served reflects the principles of recovery, self-determination, person centered planning and choice. The plan will identify specific measures that will be used to assess progress. The plan will address:*

- *The role of senior leadership*
- *Workforce development*
- *Treatment planning*
- *Design of the clinical record*
- *Resident activities and opportunities*
- *Relationship to the community*
- *Other areas ad determined relevant to enhancing the recover experience of those who are served by the facility*

The plans will be completed and submitted to your office, by the Office of Facility Operations no later than August 30, 2007.

Recommendation 2: It is recommended that each facility prepare a semiannual report that provides an update on progress toward all aspects of the Comprehensive Facility Plan on Recovery and that this report is submitted to the OIG no later than the end of February and August of each year in 2008 and 2009.

DMHMRSAS Response: *The Assistant Commissioner for Facility Management at DMHMRSAS will ensure a semiannual report which provides an update on progress towards all aspect of the Comprehensive Facility Plan on Recovery will be submitted to the OIG no later than the end of February and August of each year in 2008 and 2009.*

Section II

Background of the Study

About the Office of the Inspector General

The Office of the Inspector General (OIG) is established in the VA Code § 37.2-423 to inspect, monitor and review the quality of services provided in the facilities operated by the Department of Mental Health, Mental Retardation & Substance Abuse Services (DMHMRSAS) and providers as defined in VA Code § 37.2-403. This definition includes all providers licensed by DMHMRSAS including community services boards (CSB) and behavioral health authorities (BHA), private providers, and mental health treatment units in Department of Correction facilities. It is the responsibility of the OIG to conduct announced and unannounced inspections of facilities and programs. Based on these inspections, policy and operational recommendations are made in order to prevent problems, abuses and deficiencies and improve the effectiveness of programs and services. Recommendations are directed to the Office of the Governor, the members of the General Assembly and the Joint Commission on Healthcare.

Selection of the Recovery Experience for Review

Virginia state government has an ongoing performance evaluation system that requires all departments to establish and monitor progress toward specific goals and objectives for the benefit of the citizens they serve. These efforts are to produce outcomes that are measurable. DMHMRSAS has established the following goal:

> *Fully implement self-determination, empowerment, recovery, resilience, and person-centered core values at all levels of the system through policy and practices that reflect the unique circumstances of individuals receiving MH, MR, or SA services.*

To achieve this goal in the state hospitals, the following outcome measure has been established by DMHMRSAS:

Measure 43014.01.01

Percentage of consumers whose experience reflects recovery, self-determination, and participation

Measure Type: *Outcome* ***Measure Frequency:*** *Annually*

Measure Baseline: *New measure -baseline data is not available. Baseline will be determined by July 2007.*

Measure Target: *15 percent increase in the number of state hospital consumers whose experience reflects the concepts of recovery, self-determination, person-centered planning, and choice by the end of FY 2008.*

Measure Source and Calculation: *Survey conducted by the Office of the Inspector General consisting of a sample of consumer chart reviews and observation and interviews with staff. Results will be provided to the Department.*

This review by the OIG was conducted to provide for the assessment of this measure and to establish a baseline against which future progress can be measured.

Other Reasons for Conducting this Review

- The recovery model is without doubt the dominant force for change and growth in the mental health field. It is now endorsed by all relevant offices of the the federal government (NIMH, SAMSHA, and the President's New Freedom Commission on Mental Health), most state mental health systems, major service recipient groups, advocacy and public education organizations, and major academic and research institutions. It is an international movement with active dialogue among many countries.
- The Commissioner of DMHMRSAS has made the recovery model the guiding principle for the DMHMRSAS Vision, System Transformation Initiative, and its Strategic Plan.
- Virginia's system of publicly funded mental health services is composed of state hospitals that are directly operated by DMHMRSAS and a vast network of community-based services that are operated by local government and private providers. Because the state hospitals are an operational unit within DMHMRSAS and are funded primarily with state general funds, DMHMRSAS should have the most direct oppportunity to advance it's vision for recovery in these settings.
- The Virginia state hospital experience features the most concentrated, intensive array of multi-disciplinary treatment expertise available in any mental health setting in the state. Often, diagnoses and treatment models that begin at the state hospital continue to influence care for the rest of the person's life. It is critical that all of these resources be guided by the recovery model.
- The pyschiatric hospital setting has many features that are antithetical to the principles of the recovery model – isolation from the community, involuntary commitment of large numbers of people with challenging conditions located in one setting. It is imperative that the principles of the recovery model be put in place to guide treatment in this setting that is the most restrictive.

Design of the Review

Defining the Recovery Model.

The OIG began the review process by conducting an extensive literature search on the recovery model. Abundant and detailed literature is available for the recovery model and its value in providing services to persons with mental illness. While there is no single authoritative source on what constitutes the recovery model, and there are many unique perspectives on this rapidly developing issue, a broad consensus exists around the basic elements. Much less common in the literature are references on methods for evaluating the presence or effectiveness of recovery-based treatment, though this is a rapidly growing field of research and writing. Even fewer resources are specific to evaluation of the provision of recovery-based treatment in inpatient settings.
The OIG selected the SAMSHA National Consensus Statement on Mental Health Recovery [1] as the definition of recovery and indicators of quality for this review. The elements of the Consensus Statement include the following:

1. **Self-Direction**: Consumers lead, control, exercise choice over, and determine their own path of recovery.
2. **Individualized and Person-Centered**: There are multiple pathways to recovery, unique to each person.
3. **Empowerment**: Consumers have the authority to choose from a range of options and to participate in all decisions.
4. **Holistic**: Recovery encompasses an individual's whole life, including mind, body, spirit, and community.
5. **Non-Linear**: Recovery is not a step-by step process but one based on continual growth, occasional setbacks, and learning from experience.
6. **Strengths-Based**: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals.
7. **Peer Support**: Mutual support - including the sharing of experiential knowledge and skills and social learning - plays an invaluable role in recovery.
8. **Respect**: Acceptance and appreciation - including protection of rights and eliminating discrimination and stigma- are crucial in achieving recovery.
9. **Responsibility**: Consumers have a personal responsibility for their own self-care and journeys of recovery.
10. **Hope**: Hope is the catalyst of the recovery process.

[1] (The National Consensus Statement on Mental Health Recovery is available at SAMHSA's National Mental Health Information Center at www.mentalhealth.samhsa.gov or 1-800-789-2647. Excerpted here, complete text is available in the appendix of the online version of this report.

Input to the Process

Input to the design of the review was received from DMHMRSAS leadership, state mental health facility directors and other hospital staff, persons who are receiving mental health services, and advocates. Input meetings were held with DMHMRSAS top leadership in mid-October, 2006. Telephone conferences were held with facility directors (and other facility staff) on October 24, 2006, and with consumers and advocates on November 2. Invitations for written input were extended to a wide range of officials and stakeholders. OIG staff solicited input on an informal basis at many different settings during the late fall of 2006. Mary J. McQuown, REACH Program Director, service recipient and advocate, provided consultation to the OIG regarding study design, questions to elucidate quality measures, suggestions for observations, and recruitment of consumer inspectors.

Development of Survey Instruments

Following the extensive input process, the OIG decided to assess the recovery experience at the mental health facilities using seven approaches:

- Review of treatment planning/clinical records for a sample of persons receiving services at the hospital.
- Interviews with these same persons
- Observation of living unit activities
- Observation of psychosocial rehabilitation activities
- Observation of treatment team activities
- Interviews with program staff at the hospitals
- Questionnaires completed by the hospital senior leadership

OIG staff developed structured interview instruments for each setting, addressing each of the elements of the recovery model, many from more than one point of view. Where possible, these interview instruments were based on questionnaires or other evaluation tools found in the professional and consumer literature or tools that had been used before in Virginia.

The Recovery Experience Outcome Measure

The record review and consumer interview are specific to individual persons receiving services at the hospital. Scores on these two items combined form the basis for the overall Recovery Experience Outcome Measure for DMHMRSAS – percentage of persons whose experience reflects the principles of recovery, self-determination and participation.

- **Record reviews**. By policy and clinical tradition, the clinical record is the official, comprehensive description of the diagnosis, treatment plan, and treatment record for persons served at state mental health facilities. It is the only permanent, official statement of what transpired in the treatment experience for a service recipient. It is designed to collect and share the different perspectives on a person's needs, strengths, and plans from all the disciplines engaged in treatment at the hospital – and, it is hoped, from the perspective of the person served. To the degree that a service recipient's treatment is based on recovery model principles, this should be evident in the clinical record.

  The record review instrument used in the study assessed whether the treatment goals in the plan expressed the person's own goals and preferences, in his or her own words. It measured the degree to which the person participated in creation of the treatment plan, the degree of choice granted to the service recipient, and the relevant involvement of family members and advocates chosen by the person. The record review also measured the use of recovery language and principles, whether treatment planning was holistic and showed a whole person with a variety of needs, strengths, and goals, and the degree to which the record focused on helping the person experience a rich, full life beyond the facility.

  This instrument contained thirteen yes or no questions. The percentage of "yes" answers on the record review constituted one element of the Recovery Experience Measure. The record review instrument was tested in development at WSH on November 9, at ESH on November 13, and again at WSH on December 7.

- **Service Recipient Interviews**. The service recipient interview was a 33-item questionnaire administered in person, one-to-one or in very small groups of 2-4 persons at various sites in the facilities, often on weekends or evenings. A shortened version of the interview was used for persons served on geriatric units at CAT, ESH, and PGH. Fifteen of the questions were created by OIG staff based on the basic principles of recovery. These were yes or no questions on issues such as what choices they were able to make themselves, the degree to which they guide and select their own treatment, what helped them the most and least in their hospital experience, etc. Eighteen other questions were based on the Recovery Oriented Systems Indicator Measure or ROSI[2]. The ROSI is becoming very widely used by mental health programs, as well as advocacy or service recipient groups, to measure the impact of the recovery model on services, agencies, and the personal experiences of service recipients. Like all consumer feedback questionnaires, ROSI tends to elicit a high level of positive answers in the majority of interviews, but it remains by far the most widely used method of seeking service recipient feedback. The percentage of "yes" answers on the consumer interviews constituted a second element of the Recovery Experience Measure.

[2] *Recovery Oriented Systems Indicator Measure (ROSI),* Dumont, J.M., Ridgway, P., Onken, S.J., Dorman, D.H., and Ralph, R.O., at National Technical Assistance Center for State Mental Health Planning (NTAC) Publications and Reports, <http://www.nasmhdp.org/>

- **Individual Recovery Experience Score** - The two elements (results of record reviews and service recipient interviews) were matched for each of the 309 service recipients in the sample and combined to yield a Recovery Experience Score for each individual. A detailed explanation of the procedure that was used to calculate a combined Recovery Experience Score for all eight mental health facilities and a separate score for each facility can be found in Section III of this report.

Other Measures

- **Residential unit and Psychosocial Rehabilitation Services (PSR) observations** were based on OIG-developed instruments that identified evidence of the elements of recovery in practice in each setting. The percentage of yes answers for the questions that were observed and rated on each questionnaire comprised the score for each type of observation (PSR and residential unit). Observations were conducted in 91 PSR classes and 70 (100%) of the residential units. (Some wings of floors were combined when determined appropriate.) The unit and PSR observations were not tied to specific consumers, but do contribute to an overall assessment of the adoption of the recovery model at Virginia's public mental health facilities.

- **Treatment team observations** were scored in a similar fashion to the PSR and residential unit observations. OIG observers used a 23-item yes or no checklist to note recovery-based treatment indicators during the treatment team meetings. OIG inspectors observed treatment team sessions for 40 service recipients.

- **Staff interviews** completed the assessment of the recovery model at each hospital site visit. The staff interview was a 29 question self-administered questionnaire. Nine of the questions were developed by OIG staff based on input and the recovery model literature. Twenty of the questions came from a new scale designed to assess staff knowledge and attitudes toward recovery, the Recovery Knowledge Inventory[3]. Staff knowledge and attitudes about recovery are among the most accessible "levers" that hospital leadership can engage (by training and leadership), and these qualities are easily measured. With a two-day notice provided to the hospitals, hospital directors were asked to notify all program staff that they should attend one of many scheduled interview opportunities during each OIG visit. With exceptions for necessary coverage of direct services, all staff were expected to attend. Recognizing that direct care staff often cannot attend such sessions during the workweek, OIG inspectors interviewed as many direct service staff as possible during unit visits, often on evenings and weekends. The OIG interviewed a total of 582 staff.

[3] *The Recovery Knowledge Inventory: Assessment of Mental Health Staff Knowledge and Attitudes about Recovery*. Luis E. Bedregal, Maria O'Connell and Larry Davidson, Yale University, in Psychiatric Rehabilitation Journal, Fall 2006, Volume 30, Number 2.

- **Executive leadership interview –** OIG staff interviewed the executive team at each facility for background and overview information.

- **Follow up questionnaire** – After the visits, hospital directors were asked to complete a follow-up questionnaire that assessed other indicators of the recovery experience.

All survey questionnaires and checklists can be found in the appendix of the version of the report that is located on the OIG website (www.oig.virginia.gov).

Process of the Review

Each of Virginia's adult psychiatric hospitals was reviewed, including:

- Catawba Hospital (CAT)
- Central State Hospital (CSH)
- Eastern State Hospital (ESH)
- Northern Virginia Mental Health Institute (NVMHI)
- Piedmont Geriatric Hospital (PGH)
- Southern Virginia Mental Health Institute (SVMHI)
- Southwestern Virginia Mental Health Institute (SWVMHI) – adolescent unit excluded
- Western State Hospital (WSH)

Population sample - At each facility, an initial sample of 25 percent of the hospital's total population was drawn at random for interviews and record reviews from the latest available DMHMRSAS census data, less the following exclusions: persons who had been in the hospital less than two weeks, persons in the hospital for forensic evaluation purposes only, persons in forensic categories whose length of stay exceeded five years, and children. This initial sample of 368 persons was reduced during the interview process by persons who refused interviews, were not available, or were not able to participate. When possible, substitutions were made by random selection (although staff suggestions were accepted concerning comprehension and communication skills of residents). It was not possible to find an appropriate replacement for everyone in the original sample, thus the study sample was smaller. The actual sample of 309 persons who completed personal interviews and had their records reviewed was 21% of the total population of 1474 at the eight hospitals at the start of the project.

Staffing – The OIG inspection team included Cathy Hill, John Pezzoli, and Jim Stewart and part-time consulting staff Frank Darpli, Lyn Hall, Clyde Hoy, Kenneth Moore, Karen O'Rourke, Jonathan Weiss, and Ann White. Pat Pettie was responsible for data entry, tabulation, and presentation, working with Stevie Burcham. John Pezzoli served as Project Manager for this review.

Three of these inspectors are consumers who participated in all but one hospital visit (Western State Hospital – due to the inspector's unexpected unavailability on the day of the visit). Each of these individuals is a Wellness Recovery Action Plan (WRAP) trainer at Virginia's hospitals and community programs. No one was asked to inspect the hospital at which he or she had worked as a peer provider or WRAP trainer. All consumer inspectors voluntarily shared with those they interviewed that they had personally experienced psychiatric hospitalization.

Phases of the Review

- Phase I - Announced visits to each hospital
    - Hospital visits occurred between December 17, 2006 and February 5, 2007.
    - Each visit included the following:
        - Residential unit observations
        - PSR observations
        - Service recipient interviews
        - Service recipient record reviews
        - Staff interviews
    - Most visits included Sunday and/or evening observations of residential unit activity, service recipient interviews, and staff interviews.
    - Visits lasted two to three days, depending on the size of the facility.
    - OIG teams ranged from three to eight persons per hospital, depending on the size of the facility.

- Phase II - Unannounced observations of treatment teams

    - By deploying inspectors to multiple facilities at the same time, the OIG conducted unannounced observations of treatment teams simultaneously on February 6, 2007 (SWVMHI, CAT, ESH, and NVMHI), February 7, 2007 (SVMHI and CSH), and February 8 (WSH and PGH).
    - Inspectors requested the permission of the service recipient and any family members present before observing the treatment team session.

- Phase III - Facility follow-up questionnaire

    - On February 16, 2007, each facility director received a message from the Inspector General with a ten-question survey that was to be completed and returned to the OIG by March 2.
    - The survey was announced to be subject to external verification.
    - The survey requested information about certain recovery activities during the period of October 1, 2006 through December 31, 2006.

Section III

Outcome Measurement of Recovery Experience

The principal objective of this Review of the Recovery Experience of Individuals Served at DMHMRSAS Operated Mental Health Facilities is to establish a score by which to measure one of the stated outcomes for DMHMRSAS - the percentage of persons served whose experience reflects recovery, self-determination and participation. The results of this review constitute a baseline for future assessments of the recovery experience. The DMHMRSAS outcome measure calls for a 15 percent increase each year in the number of persons whose experience reflects recovery, self-determination and participation.

The Service Recipient Interview and Record Review are specific to individual persons receiving services at the hospital. Scores on these two instruments have been combined to form the basis for the overall outcome measure score for DMHMRSAS: the percentage of persons whose experience reflects recovery, self-determination and participation.

The results displayed below combine findings for all eight mental health hospitals. Detailed results, by facility, are available in the appendix of the online version of this report.

1. Record Reviews

The clinical records of the persons selected for interviews were reviewed for recovery-based treatment variables. The data below combines information from all eight mental health facilities.

Record Review *	**% Yes**	**% No**
Does the treatment plan meaningfully elicit and incorporate the consumer's own goals, in his or her own words?	14	86
Was the consumer present at most treatment team meetings?	81	19
Does the documentation show that the consumer actively participated in the TPC, or that the TPC made efforts to facilitate meaningful participation?	48	52
Was there a family member, friend, or advocate present at any of the planning meetings?	29	71
Is the treatment plan specific and individualized with regard to goals and treatment for life beyond the hospital, rather than just a focus on stabilization of symptoms, eradication of behaviors, etc.?	46	54
Do the treatment planning documents relate to a wide variety of life skill/need areas (housing, job, education, social, health, spiritual, etc) – showing a holistic view of the person, rather than a focus only on symptoms and behavior change?	40	60
Does record show clear involvement of the consumer with regard to his or her return to the community?	48	52

Is the hospital providing education for the patient to become empowered, hopeful, and engaged in dealing with his own illness, symptoms, medications/side effects, relapse prevention, etc.	61	39
Did the consumer receive an assessment of co-occurring substance abuse treatment needs?	88	12
If substance abuse needs are identified, is treatment addressing co-occurring MI/SA needs?	69	31
Does the hospital provide training in self help and community skills that are responsive to this person's perceived deficits and/or need to fulfill life plans or goals?	89	11
Can the record be generally characterized as showing respectful, accepting, supportive, and non-judgmental treatment?	98	2
Can the record be generally characterized as using person-first language?	4	96

* If a person's age, health condition or forensic status was deemed by the OIG inspector to render a question in the Record Review as less relevant, the question was rated as Not Applicable. The data presented above are based on the total number of individuals for whom each question was answered. The number responding to each question is shown in the results for this measure in the appendix.

- Record reviews revealed that 14% of records at all the hospitals combined had goals in the individual's own words or reflecting his or her direct input.
- Western State Hospital uses a form which invites the resident to express his or her goals and dreams for the future in his or her own words. It is part of the treatment planning section of the record; however, these forms are not often included in wording of the actual treatment plan. Nevertheless, 47% of WSH patients had goal statements in their own words in their files, by far the most among all eight hospitals.
- While records showed that 81% of the persons served were at their own treatment team meetings, about half (52%) were documented to have participated significantly. OIG inspectors had difficulty finding evidence of the person's participation, as the treatment plan record documents did not typically give importance to this issue.
- Very low participation of families, friends and advocates was documented in the records (29%). Literature on recovery-based treatment emphasizes the usefulness and fairness of having advocates or trusted persons to provide support during these important processes.
- Less than half (46%) of treatment goals and plans focused on helping people become ready for life in the community. The majority (54%) merely focused on symptom reduction and behavior change in the hospital. Most kept the same goals over extended review periods, updated only by marking out previous dates and substituting new ones.
- Similarly, 40% of the plans that were reviewed were considered to be holistic, showing a whole person being helped (looking at employment, health, social, housing, and other goals). The majority, 60%, showed a person mainly defined by psychiatric symptoms.
- Very few records (4%) were judged to contain primarily "person first" or recovery model treatment language.

- Without exception, the records of the facilities are organized and structured for a traditional, deficit-based treatment model of care. The records are not structured to "cue" or stimulate recovery-based treatment considerations or language by the treatment team. Sections in the record, forms, or questions on forms can help to assure that recovery-based treatment thinking occurs and is documented. At most facilities (WSH excepted) there is no specific place for the person to state his or her own goals and plans in the records.
- Each hospital has a completely different approach and format for records. The utility of this variety, system wide, is not apparent. Good ideas found in one hospital are not evident in others. Each has seemingly "invented its own wheel".

2. Service Recipient Interviews

OIG inspectors interviewed 309 individuals who were receiving services at the eight hospitals at the time of the review.

Facility	Number of Persons Interviewed
CAT	23
CSH	46
ESH	87
NVMHI	28
PGH	27
SVMHI	16
SWVMHI	32
WSH	50
Total	309

The results for the recipient interviews for all eight mental health facilities combined are displayed below in three separate charts which group questions into three primary areas: opinions of care, choice and ROSI.

Interview with Persons Served – Opinions of Care *	**% Yes**	**% No**
Did you have input to your treatment goals and plan?	69	31
Have you discussed what it will take to be able to leave the hospital?	73	27
Do you believe that your mental health condition will improve?	91	9
Does the staff believe that your mental health condition will improve?	84	16
Is there someone at the hospital that you can relate to, trust, and count on?	79	21
Do you feel the rules about privilege level are fair?	70	30
Do you like the food?	65	35
Do you feel safe at this hospital?	75	25

* Some service recipients did not answer every question. When persons served in geriatric units at CAT, ESH and PGH were interviewed, certain questions were omitted to decrease the effort required for completion of the interview. The data presented above are based on the total number of individuals for whom each question was answered.

- Almost a third (31%) of the sample said they did not have input to their treatment goals and plan, a finding of concern for a key principle of recovery-based treatment.
- Over a quarter (27%) of those interviewed said they had not had a discussion with their treatment team about what will need to happen for them to be able to leave the hospital and return to life in the community.
- A very high percentage (91%) of persons showed hope about recovery from mental illness – a key component of recovery. Nearly as many (84%) believed that staff shared that hope for them – a positive finding for recovery-based treatment.
- The recovery model emphasizes the importance of helping, healing connections among people. 79% of the respondents said there was someone that they could trust, relate to, and count on at the hospital. The respondents were also asked to identify the roles of the persons whom they most trusted and counted on. Data displayed below shows the frequency with which different roles were identified, across all hospitals:
    - Doctors 33%
    - Nurses 20%
    - Direct service staff (aides) 18%
    - Social workers 18%
    - Other patients, consumers 9%
    - Psychologists 5%
    - Other 6%
- One quarter of those interviewed (25%) said that they do not feel safe at the hospital. Almost all who expressed this opinion identified other patients as their concern, not staff. It is very difficult for individuals to have a recovery experience in an environment that they perceive as unsafe for them personally.
- While good food is not a recovery-based treatment element, a comfortable, satisfying environment is good for morale and motivation. Somewhat over half (65%) said they liked the food, even without choice of menu items.
- Residents were asked the question, "**What is it about the care you receive at this hospital that helps you the *most*?"** Leading responses included the following:
    - 26% made positive comments about the staff
    - 22% said "nothing" – a negative reaction, meaning they found nothing helpful.
    - 16% said medications helped them the most.
- Residents were also asked the question, "**What is it about the care you receive at this hospital that helps you the *least*?"**
    - 31% said "nothing" – a positive comment, meaning they did not identify anything that was unhelpful.
    - 14% made negative comments about the staff.
    - 13% said the lack of freedom was unhelpful.

Interviews with Persons Served – Choice *	% I Decide	% No Choice	% Shared Decision
What I eat at meal time	25	54	21
When I go to sleep or wake up	52	31	17
Whether I share a room and with whom	16	69	15
What I wear each day	80	17	3
What is in my treatment plan	8	46	46
What classes I take at the PSR	25	37	38
Whether I take medications, which ones	11	60	29
When I am ready to be discharged	10	63	28
Where I will go when I leave the hospital	37	27	35

* Some service recipients did not answer every question. When persons served in geriatric units at CAT, ESH and PGH were interviewed, certain questions were omitted to decrease the effort required for completion of the interview. The data presented above are based on the total number of individuals for whom each question was answered.

- Over half (54%) of the residents said they had no choice of meals and 21% said they had to share decisions with staff about what they would eat. Many of those that said they had some choice, referred to an indirect process of communications sent to the nutritionists, which would eventually lead to substitutions for dislikes. Many mentioned that they were on a prescribed diet. (Patient consent to diet limitations to treat physical health concerns was not explored). OIG found little food choice of the sort that most people would expect to have in a community hospital.
- Choice was limited in other areas of personal preference in activities of daily living. Sleep hours were freely chosen by 52%, room arrangements by 16%. 80% said they chose their own clothing each day.
- Very few persons (8%) stated that they directed their own care through their treatment plan. 46% felt they shared in decisions about their treatment plan with hospital staff. But just as many (46%) declared that they had no choice in their treatment plan; however, OIG record reviews for these same individuals showed that 81% of them attended the majority of their treatment team meetings. This is of significant concern.
- Even fewer individuals felt that they had a real role in their medication decisions. 29% said they had a partnership in this with their doctors. 11% of the service recipients said they decide which medications they take.
- 63% say they have no choice in discharge decisions, and 27% believe they have no choice about where they will go if discharged. All the indicators of personal choice indicate needs for improvement in communication and shared decision-making in order to achieve recovery-based treatment.

Interviews with Persons Served – ROSI*	% Strongly Disagree	% Disagree	% Agree	% Strongly Agree
Most staff at this hospital listen carefully to what I have to say.	9	23	57	11
Most staff at this hospital see me as an equal partner in my treatment program.	19	23	47	11
Most staff at this hospital understand my experience as a person with mental health problems.	12	20	56	12
I feel I have a say in the treatment I get here.	14	21	52	12
Staff at this hospital have used pressure, threats, or force in my treatment.	20	41	30	9
The doctor has worked with me to get me on medications that are most helpful to me.	9	19	59	17
Staff at this hospital interfere with my personal relationships.	17	44	31	9
Services at this hospital have caused me emotional or physical harm.	17	53	22	8
There is at least one person at this hospital that believes in me.	4	14	60	22
Staff at this hospital believe that I can grow, change, and recover.	5	15	61	19
My treatment goals (in my treatment plan) are stated in my own words.	14	39	39	8
There is a consumer or peer support person I can turn to when I need one.	10	21	48	20

* Key ROSI items were selected for this display. Complete results are available in the appendix of the online version of this report. Please see Consumer Totals. Some service recipients did not answer every question. When persons served in geriatric units at CAT, ESH and PGH were interviewed, certain questions were omitted to decrease the effort required for completion of the interview. The data presented above are based on the total number of individuals for whom each question was answered.

- 53% of respondents disagreed with a statement that **"my treatment goals are stated in my own words."** Self-determination of treatment goals is fundamental to recovery-based treatment. As seen above, OIG review of the actual records of these same persons revealed that 14% had goal statements in their own words.
- 42% of respondents disagreed with a statement that **"staff see me as an equal partner in my treatment program."**
- 40% agreed with the statement that **"staff interferes with my personal relationships."**

- 35% disagreed with the statement that they **"have a say in their treatment"** at the hospital.
- 32% of respondents disagreed with the statement that staff **"listen closely to what I have to say"** and the statement that **"staff understand my experience as a person with mental health problems."**
- It is of concern that 30% agreed with a statement that **"services at this hospital have caused me emotional or physical harm."**
- It is of concern that 39% agreed with the statement that staff **"have used pressure, force, or threats."**

3. Measurement of the Recovery Experience

The table below displays the Recovery Experience Score for all eight mental health facilities combined and then for each facility individually. The combined Score for all eight facilities was calculated as follows:

- Step One: For each individual in the sample, the total number of "yes" answers on the Consumer Interview questionnaire was divided by the total number of "yes" and "no" answers on this same instrument to obtain an average number of "yes" answers. Questions that individuals did not answer or that were judged to be "not applicable" or "not observed" were dropped in computing the individual's average.
- Step Two: This process was then repeated with the responses to the questions on the Record Review form for the same individual.
- Step Three: For each individual, the average number of positive answers on the Consumer Interview questionnaire and the average number of positive answers on the Record Review form were added together and divided by two to obtain a Recovery Experience Score for the individual.
- Step Four: The Recovery Experience Score for each individual was compared to an expected minimum standard of 85%. If the Recovery Experience Score was 85% or above, the individual was determined to have had an experience that reflects recovery, self-determination and participation. If the Recovery Experience Score was below 85%, the experience was not determined to reflect these principles adequately.
- Step Five: The number of individuals with a score of 85% or above was then divided by the total number of individuals in the sample to obtain a Recovery Experience Score for all eight facilities combined.

This same procedure was repeated for each facility to obtain separate Recovery Experience Scores for each of the eight facilities.

The overall percentage of individuals whose experience was determined to reflect recovery, self-determination and participation is 4.9 percent. This is the Recovery Experience Score for all eight facilities combined.

The Recovery Experience Score						
Facility	**Number of Individuals in Sample**	**Number of Individuals Having Recovery Experience**	**Number of Individuals Not Having Recovery Experience**	**Recovery Experience Score (%)**	**Mean (Average) Recovery Experience Score (%)**	**Median (Midpoint) Recovery Experience Score (%)**
All Eight MH Facilities Combined	309	15	294	4.9	58.7	59.3
CAT	23	0	23	0	56.8	57.1
CSH	46	3	43	6.5	59.3	60.6
ESH	87	2	85	2.3	50.7	50.2
NVMHI	28	2	26	7.1	68.9	68
PGH	27	0	27	0	52.4	50
SVMHI	16	5	11	31.3	75.7	72.9
SWVMHI	32	1	31	3.1	61.1	61.1
WSH	50	2	48	4	63.9	65.9

Section IV

Other Assessments of the Recovery Experience

1. Residential unit observations

OIG inspectors made unannounced visits to each residential unit of each of the state mental health facilities. Inspectors' time on the residential units averaged 40 minutes per unit. 100% of the residential units (70 units) were observed.

Hospital Residential Unit Observations*	**% Yes**	**% No**
Did most staff interact with the consumers in a respectful, courteous manner?	92	8
Did most staff make an effort to involve and engage all consumers, excepting those who clearly refused to participate after being invited?	47	53
Were most staff interactions warm, accepting, and welcoming to consumers?	88	12
Did most staff seek to offer consumers choice on all matters possible?	61	39
Were there interesting options available for consumer choice for self-directed activities? (e.g., games, books, videotapes, etc.)	42	58
Was there any evidence of consumers filling valued roles in unit life (e.g., peer support, unit governance, leading meetings, etc?)?	25	75
Are meals typically served in a dedicated dining room, off the unit, or, at least, not in the day activity/living area?	47	53
Do residents have choice of what they eat at meals?	19	81
Was there a place where consumers could enjoy private, quiet time, to read, for example, other than the day room or their bedroom?	51	49
Was the unit furnished with comfortable, pleasant, "homey" furnishings (e.g., furniture, carpeting, curtains, wall décor, etc.)?	44	56
Did the consumers have privacy? In sleeping arrangements (e.g., a private room or choice of having a roommate)	12	88
Did the consumers have privacy - in toilet and bathing facilities? (doors that close – not curtains - for commodes).	64	36
Were there any books, videotapes, brochures, posters on recovery-relevant topics (mental illness information, WRAP plans), medication information, etc.?	15	85
Did residents have reasonable access to a computer with internet access?	13	87

* Key questions are excerpted here. The full observation checklist, by hospital, is found in the appendix of the online version of this report. Please see Unit-Staff Totals.

- The key observation was that at most hospitals, the level of staff interaction with the persons served was very low –47% of the observations documented staff making efforts to involve and engage persons on the units. In 53% of the observations, there was no significant interaction taking place.

- Overall, far less interaction occurred than OIG inspectors judged appropriate and desirable. The observation of staff sitting in or near the unit office was more common than OIG staff considered appropriate. At one facility, ESH, some staff members said they were told not to interact with residents too much, because this would distract them from their primary mission – assuring that no accidents occur.
- When staff did interact with hospital residents, the interactions were positive: 92% were judged to be respectful and courteous, 88% were warm, accepting, and welcoming. When interactions did occur, staff were frequently (61%) seen to be offering choice among leisure activities, time to do laundry, etc.
- Recovery-based treatment principles stress the importance of persons defining themselves through hobbies, interests, etc, rather than solely by their illnesses. Most of the units lacked activities that might stimulate interests or relieve boredom. Only 42% of the units had some magazines, books, and games available. Most were out-of-date, incomplete, tattered, and dull. More than half (58%) had nothing. Almost no newspapers were seen in any units in any hospital. Televisions blared incessantly, often without viewers. Some units had newer or better maintained supplies, but they were kept under lock. All facilities boast excellent libraries, but access to them is dependent on privilege and library schedules, which are limited at many hospitals.
- Very few units (15%) had much in the way of posters, brochures, books, or videotapes on mental illness, medication, recovery, or wellness topics. Of those that did, most collections were minimal. Better resources were in the libraries, but as noted, access is limited. Catawba Hospital does a good job of posting recovery messages on most walls in common spaces.
- An overall average of 25% of the units were scored as offering some form of valued role for residents. However, in these units this activity was most often participation in unit meetings at which people were given some opportunity to raise issues, chair meetings, etc. Meaningful social role opportunities for residents such as mentoring, peer support, clerical or administrative assistance, were not observed in units anywhere.
- At most hospitals little choice in meals is afforded to residents (19%), and most choice is limited to requests to the kitchen to substitute disliked items in future meal service. These observations by OIG inspectors are similar to responses to consumer interviews, in which 25% said they had choice of meals. At Catawba Hospital residents have choice among entrees in the cafeteria, even when they may be on a restricted diet.
- In over half of the observed units the residents must take their meals in the same space where they spend most of their time - on the living unit – a highly institutional model. At some hospitals, identical, covered plastic trays are removed from a cart or from the cook-chill unit, residents' names are called out, and the people eat their meals where they spend their leisure time – in the day room of their living unit. NVMHI's recently renovated dining room drew praise from all inspectors.
- Quiet places to read, relax, and be alone are hard to find at almost half of the units that were observed.
- Privacy in sleeping arrangements is severely limited at most hospitals – only 12% of the persons had choice about where or with whom they shared a room. Few private rooms exist, and these are more often assigned for security reasons, rather than a

person's choice or privacy interests. Bathrooms are generally harsh, institutional, and not very private, but at 64% of the residential units observed there are doors that close for the commodes and shower curtains (36% lack even these features). Two facilities – NVMHI and SVMHI – have private bathrooms in each two-person room.

- Reasonable efforts have been made to decorate and "warm up" day rooms, corridors, and other public spaces at half (44%) of the units. Many of the older buildings look like what they are - aged institutions, designed under an outdated set of treatment values. All inspectors noted the many recovery posters and messages at Catawba Hospital, and the delightful "blue sky and cloud" fluorescent light panel covers – small touches that enliven and warm a building from another era of care.
- The extensive use of carpeting in corridors and common spaces at NVMHI was noted as an excellent feature that warms and quiets the environment. Facility staff agreed, noting that the high maintenance requirements were more than offset by the environmental improvements.
- At most hospitals, much more could be done to decorate the sleeping rooms, preferably with items chosen or produced by the residents. Most rooms at most hospitals were barren and said nothing about the person(s) living there.

Ratings for residential unit observations

This table shows the residential unit ratings for all hospitals combined and for each individual hospital. The rating for all eight hospitals combined is the total number of "yes" answers divided by the total number of "yes" and "no" answers. The rating for each individual hospital is calculated in the same way.

Residential Unit Observations	**% yes**
Total of all 8 facilities	49
CAT	58
CSH	44
ESH	36
NVMHI	73
PGH	68
SVMHI	77
SWMHI	47
WSH	55

2. Psychosocial Rehabilitation Services (PSR) Observations

OIG inspector teams observed 91 PSR classes across the eight hospitals.

PSR Observations*	% Yes	% No
Did the staff typically interact with the consumers in a respectful, courteous manner?	99	1
Did the staff typically make an effort to involve and engage all consumers, excepting only those who clearly refused to participate after being invited?	95	5
Was most staff interaction with consumers warm, accepting, and welcoming?	95	5
Was there class involvement of a peer instructor, class assistant, etc. – was any consumer performing a valued role?	20	80
Was the class conducted in an age-appropriate, learning-oriented manner?	97	3
Was their good attendance? (80 % of enrolled students)	76	24
Did the staff encourage residents to do what they could for themselves, rather than doing most things for them without checking?	96	4
Were the majority of the class members engaged, interested, and attending to the session (rather than bored, not listening, etc.)?	91	9
Did the staff use recovery-oriented language in speaking to or about students?	57	43

* Key questions are excerpted here. The full observation checklist, by hospital, is found in the appendix of the online version of this report. Please see Unit-Staff Totals.

- Staff interactions with residents in the PSR setting were rated very highly. Staff typically interact with consumers in a respectful manner (99%), make an effort to involve and engage residents (95%), and interact with residents in a warm, accepting and welcoming manner (95%).
- Classes were judged to be generally age-appropriate, though there were a few instances where the material was deemed too basic for the participants and the instructor's tone was considered condescending.
- Attendance in class and personal engagement with the class activity are critical factors for learning. Attendance was good and well monitored at most facilities, but with significant exceptions at others, which are noted in the detailed tables in the appendix.
    - At CSH and ESH much potential "time-on-task" was lost with completing residential unit activities before transportation to the PSR center and conflicting staff requirements on residential units (Unit staff also assist with PSR activities).
    - At SVMHI, especially, and at NVMHI, to some degree, there was relatively poor attendance. This seemed to be a matter of resident choice.

    - At PGH, resident health conditions lowered attendance (along with space maintenance issues on the day of the OIG visit).
- The most glaring missed opportunity to advance recovery experiences in PSR was the lack of PSR participants filling valued roles in the treatment mall. 20% of the observations noted consumer- instructors or discussion leaders. The engagement of people as teachers, WRAP trainers, class co-leaders, peer counselors, administrative assistants, mentors, etc. provides a valuable opportunity to help build self-esteem and experience success and usefulness. This is widely lacking at all facilities.
- Given the importance of PSR to the overall experience of residents at the facility, OIG inspectors were concerned to find such a weak link between PSR activities and the treatment plan.
    - In the review of clinical records, the individual's PSR activities, including what is being learned and what progress is being made, were not found to be central to treatment planning records and treatment team discussions.
    - It was very unusual to have a PSR instructor attending a treatment team meeting at any facility, though PSR program directors were present occasionally. Most treatment team discussion or review of PSR consisted of an occasional question from the doctor, such as "How is the person doing at the treatment mall?"

Ratings for PSR observations

This table shows the PSR class ratings for all hospitals combined and for each individual hospital. The rating for all eight hospitals combined is the total number of "yes" answers divided by the total number of "yes" and "no" answers. The rating for each individual hospital is calculated in the same way.

PSR Observations	% yes
Total of all 8 facilities	77
CAT	85
CSH	73
ESH	66
NVMHI	81
PGH	80
SVMHI	78
SWMHI	84
WSH	79

3. Treatment Team Observations

OIG inspectors conducted unannounced observations of a random selection of treatment team meetings. Each inspector completed a separate checklist for each resident whose case was being reviewed by the treatment team. A total of 40 individual case treatment team sessions were observed.

Treatment Team Observations*	**% Yes**	**% No**
Was the person being served present?	90	10
Was there a family member, advocate, or other representative of the person present?	20	80
Was the CSB or other community resource present?	38	63
Was a direct service staff member present who knows the person from the unit or PSR?	35	65
Did the discussion relate to the actual goals in the plan (as opposed to recent behaviors, symptoms, medication issues)?	35	65
Were the person's own goals discussed? Was the person asked about his goals?	49	51
Did most members of the treatment team participate actively in discussions of each person – a true multi-disciplinary team?	75	25
Did the person participate? Did the treatment team address the person at appropriate points and try to engage his or her participation?	94	6
Did the group use "people first" language?	54	41
Did the discussion relate to the person in a holistic way, considering a wide range of life needs and strengths?	59	41
Did the team talk about the consumer having activities and responsibilities that are appropriate for life outside the facility?	32	68
Did they talk evaluatively with the consumer's participation about whether or not current daily activities at the hospital are fulfilling and growth producing, etc.?	38	62
Was there any consideration of whether the consumer has key helping relationships with anyone – staff, consumer, etc. - at the hospital or in the community?	28	72
Was the discussion related to "getting the person out of the hospital and back into a good life in the community," rather than just addressing ward behaviors, medication compliance, etc.?	63	37
If discharge planning was discussed, did the planning reflect the consumer's choices and preferences?	85	15
If discharge planning was discussed, did the plans contain appropriate housing, work or day support, transportation, medical services, CSB support services, highest possible level of independence, etc.?	65	35
Was the tone of the meeting or the majority of comments characterized by hope and positive expectations of recovery?	66	34
Was there enough time available for a good discussion, to not feel rushed?	83	18
Did doctor or other members of the team ask the person about how his medications were working, side effects, his satisfaction or preferences with medications?	71	29

* Key questions are excerpted here. The full observation checklist, by hospital, is found in the appendix of the online version of this report. Please see Unit-Staff Totals.

- The person being served was present for the treatment team meeting 90% of the time.
- The teams made good efforts to engage and involve the person in the discussion.
- The person was assisted in the team meeting by a friend, family member or advocate only 20% of the time, and a representative of the person's home CSB was present 38% of the time. No observation was made as to whether a person invited or rejected participation from others.
- 35% of the observations noted the presence of a direct service staff member – someone from the living unit or PSR who actually works with the resident on a daily basis.
- The treatment plan is the guide to treatment and the official record of it. However, treatment plans did not drive the observed treatment team discussions:
    - Usually, only one member of the team actually held a copy of the chart during the meetings, and copies or summaries of key documents such as the treatment plan were not available to participants, including the person being served.
    - The actual goals in the treatment plan were discussed in only 35% of the cases. 65% of the discussions were limited to symptoms, compliance, and behaviors.
    - PGH has developed a new tool for assessing recovery readiness needs and progress (the Recovery Plan), which is being phased in and was used as a basis for discussion at some treatment teams. ESH has a similar form under development that has not yet been implemented.
- The individual was asked about his or her *own* goals in half (49%) of the discussions.
- In 75% of the team discussions most members of the team participated; however, in 25% of the cases there was little team discussion. In these sessions, almost all comments were made by the physician.
- There was less discussion than OIG inspectors judged appropriate regarding whether or not the person's hospital experiences were rewarding or fulfilling (38%) or appropriate for improving chances of success in the community (32%). In 28% of the sessions was there discussion of whether or not the person had meaningful helping relationships with staff or other consumers (28%). Consideration of these issues is critical in that they reflect a focus on the person and concern about the quality of his or her experience at the hospital. Their omission is significant.
- In 54% of the observations, the teams were judged to use recovery or people-first language. This meant that the team did not talk *about* the person as though he or she were not there, but *with* him or her, that labels were not used to describe persons, and that judgmental terms such as *compliant* were not used.
- 63% of the meetings included a focus on making plans for the person to return to the community, but 37% focused mostly on ward behaviors, medication compliance, etc.
- Discussions of discharge planning were fairly complete 65% of the time and involved the person appropriately 85% when discharge was being discussed.
- While the general tenor of 65% of the discussions was hopeful and supportive of recovery, 34% of the observed discussions did not demonstrate these core recovery values.
- Some input before the study raised concerns that treatment team meetings were often rushed and too brief for persons to feel that their needs and issues had been fully

addressed. This was not a significant problem in the sessions that were observed, with seven of 40 (18%) sessions judged as feeling rushed.

- OIG inspectors at WSH, PGH, NVMHI and SVMHI reported that a significant majority of observations were consistent with the recovery model. It was felt that some of the treatment team discussions at these facilities were so good that if they could have been videotaped, they would serve as an instructive model for all such teams.
- It was the OIG inspectors' judgment that the overwhelmingly dominant variable in the tone and model of the treatment team meetings was the leadership provided by the team leader – almost always the psychiatrist. If the team leader enabled and facilitated a collegial, team-oriented, participatory discussion and personally modeled the principles of recovery, the treatment team session was significantly more reflective of recovery values, and the team partnered with the person being served.

Ratings for treatment team observations

This table shows the treatment team ratings for all hospitals combined and for each individual hospital. The rating for all eight hospitals combined is the total number of "yes" answers divided by the total number of "yes" and "no" answers. The rating for each individual hospital is calculated in the same way.

Treatment Team Observations	**% yes**
Total of all 8 facilities	55
CAT	45
CSH	39
ESH	36
NVMHI	81
PGH	81
SVMHI	69
SWMHI	43
WSH	71

4. Staff Interviews

OIG inspectors interviewed 582 staff at all the hospitals. Interviews consisted of a 27-item questionnaire and a discussion period. These findings provide a guide for needed training.

Staff Interviews by Facility	Number Interviewed	Average Length of Service (years)
Totals	582	10.5
CAT	56	10.6
CSH	83	9.8
ESH	127	12.2
NVMHI	47	4.6
PGH	60	9.2
SVMHI	53	10.3
SWVMHI	72	11.1
WSH	84	15.9

The Recovery Knowledge Inventory (RKI) is a new instrument designed to assess staff knowledge and attitudes toward recovery-based treatment. In analyzing results, the 20 questions are grouped into three components, measuring four aspects of the recovery model. The "preferred" answers are noted by each component title.

Recovery Knowledge Inventory – All staff responses	% Disagree*	% Agree*
1. Roles and Responsibilities in Recovery (disagree is preferred)		
Only clinically stable people should make decisions about their care	88	12
Recovery is achieved by following set procedures	61	39
Professionals should protect clients from failure/disappointment	74	26
Recovery is most relevant to those who have completed treatment	77	23
People receiving treatment are unlikely able to decide treatment and rehab goals	89	11
People with MI should not be burdened with life responsibilities	98	2
Recovery not as relevant for those who are actively psychotic	96	4
Mean score on Component 1 (scores are 5 to 1, with 5 optimal)	**3.9**	
Range of mean scores on Component 1	**2.29 – 5.00**	
2. Non-Linearity of the Recovery Process (disagree is preferred)		
Expectations and hope should be adjusted based on illness severity	31	69
Recovery is gradual steps forward without major steps back	49	51
The more a person complies with tx, recovery is more likely	17	83
Little can be done if the person does not accept his illness/tx needs	70	30
Symptom management is essential to recovery	9	91
Symptom management is the first step to recovery	18	82

Mean score on Component 2 (scores are 5 to 1, with 5 optimal)	**2.7**	
Range of Mean Scores on Component 2	**1.00 – 4.83**	
3. Roles of Self-Definition and Peers in Recovery (agree preferred)		
Pursuit of hobbies and leisure are important for recovery	3	97
Other recovering persons can help as much as professionals	5	95
Defining one's self, apart from the illness is essential	3	97
Recovery is equally relevant to all phases of treatment	9	91
All professionals should encourage clients to take risks to recover.	23	77
Mean score on Component 3 (scores are 5 to 1, with 5 optimal)	**4.3**	
Range of mean scores on Component 3	**1.80 – 5.00**	
4. Expectations Regarding Recovery (disagree preferred)		
Not everyone is capable of participating in recovery process	50	50
It is often harmful to have too high expectations for clients	62	38
Mean score on Component 4 (scores are 5 to 1, with 5 optimal)	**3.5**	
Range of mean scores on Component 4	**1.00 – 5.00**	

* Answers are compressed for display from strongly disagree/disagree to disagree, and from strongly agree/ agree to agree. Full results, by facility, are available in the appendix of the online version of this report. Please see Consumer Totals.

- The area of highest agreement with desired direction was the group of questions in component number three, R*oles of Self Definition and Peers in Recovery*, with a mean score of 4.3. This indicates that the respondents appreciate the need for the person in recovery to develop a positive self-identity beyond that of being a "mental patient". It also shows an understanding of the importance of peer support in the process of recovery. The only item in this section to which more than a handful of respondents did not provide the "preferred" answer was the one that stated, **"Professionals should encourage clients to take risks to recover".** 23% said they agree with this statement. Further analysis is needed to assess whether this result indicates less understanding of the role of risk in recovery or is an expression of a conflict between recovery values and organizational expectations. This latter explanation may conform with many written and oral comments by staff, which suggests that DMHMRSAS and facility instructions, policies, and culture may inhibit the kind of risk allowance that the recovery model says is necessary for growth and ultimate self-reliance.
- The next to "highest" score, mean of 3.9, was on the questions in component number one, *Roles and Responsibilities in Recovery*. This shows good understanding of the different roles of staff and persons in recovery. It also shows good grasp of self-determination, some appreciation of risk-taking and personal responsibility, and appreciation for the idea that people are "ready for recovery" when they, not staff, say they are. Training needs are suggested by the responses to the item that **"Recovery must follow a prescribed set of procedures"** (recovery is individualized), that

"Persons should be protected from failure and disappointments" (a paternalistic, risk-averse position), and **"Recovery is most relevant to those who have completed treatment"** (people can start on the road to recovery at any point, with any size steps).

- Staff scored more poorly on the two questions in component number four, *Expectations Regarding Recovery,* for which the mean score was 3.5, and, especially, on the questions in component number two, *Non-Linearity of the Recovery Process with a mean score of* 2.7. Average answers on questions in component number two depart significantly from recovery knowledge and principles. The pattern of answers suggests that a majority of staff seem to think that recovery is only for those "less sick," "more compliant," or "non-symptomatic." It also shows a failure to understand that recovery rarely proceeds onward and upward, without relapses and setbacks. These are major training and attitude gaps. Failure to recognize these variables can result in "recovery for good clients" and a lack of effort and imagination with persons who are angry, defiant, do not accept professionals' views of their illnesses or treatments, or who are very sick, or actively symptomatic.
- All staff at the hospitals must be more alert and sensitive to non-linearity issues and working with persons at the earliest stages of recovery readiness.

Other staff interview questions. In addition to the RKI, staff were asked a series of open-ended questions.

- **What hospital practices most hinder persons making progress on the road to recovery?**
  - 36% of staff respondents cited practices typical of traditional, deficit-based, medical model approaches to care (not listening to persons served, rigid programming, focus on symptoms only, limited activities, poor communication among staff, lack of individualized planning).
  - 22% cited limitations of staff to meet recovery needs due to inadequate staffing patterns, unrealistic demands of staff time, lack of time to work with people, lack of individual treatment.
  - 10% cited unrealistic expectations of persons served (persons not cooperating with their treatment, acuity of patients, mix of patients).
  - Forensic restrictions and processes, lack of community programs to facilitate discharge, and funding needs were other frequently mentioned items.
- **What hospital practices most help persons make progress on the road to recovery**?
  - 46% cited practices that are elements of the recovery model (listening to persons served, involving them in their service planning, teamwork approach among staff, effective and open treatment teams).
  - 17% specifically mentioned PSR programming.
  - 12% stressed the importance of individualized treatment.
  - 11% focused on staff skill and effort to provide quality treatment.
  - Medications and peer support were also mentioned by some staff.

- **What in your opinion is the highest priority for improving care at this facility?**
  - 46% endorsed adoption of the recovery model for treatment.
  - 32% stressed improvements in staff recruitment and retention to fill vacancies and reduce overtime.
  - 8% identified staff training.
  - Also mentioned were increasing program resources (7%) and improving staff and patient safety (6%).
- When asked if discussions at their team meetings helped them understand their roles and responsibilities in helping persons make progress on the road to recovery at their hospital, staff responded as follows:

Question: Do discussions at team meetings help you understand your role and responsibilities in helping persons make progress on the road to recovery at your hospital?

Hospital	% Strongly Disagree	% Disagree	% Not Sure	% Agree	% Strongly Agree
Total of all 8 hospitals	2%	8%	11%	54%	26%
CAT	0	6	18	0	24
CSH	2	15	11	53	20
ESH	4	6	7	46	28
NVMHI	0	5	3	53	35
PGH	2	2	4	47	43
SVMHI	0	7	11	57	17
SWMHI	6	6	19	52	17
WSH	2	4	13	56	25

Section V

Survey of Facility Initiatives

Following the visits to the facilities, the OIG sent a questionnaire to the directors of the facilities. The questionnaire explored hospitals' efforts to provide valued roles (employment, volunteer opportunities), offer peer support group opportunities, provide WRAP training and other peer support, and advance the recovery model in the hospital with families and in the communities the hospitals serve.

Facility Follow Up Questionnaire-Data (October 1, 2006 - December 31, 2006)										
	Question	**CAT**	**CSH**	**ESH**	**NVMHI**	**PGH**	**SVMHI**	**SWVMHI**	**WSH**	**TOTAL**
1	Number of residents employed at hospital:									
	As WRAP, peer counselors	0	1	0	0	0	0	0	2	3
	Other paid (e.g. food service, canteens, etc.)	0	81	89	36	0	1	30	3	240
	Total	0	82	89	36	0	1	30	5	243
2	Residents volunteering at hospital:									
	Peer supporter	0	0	0	0	0	0	0	0	0
	PSR instructor	0	0	0	0	0	0	0	0	0
	Other voluntary role	14	7	23	20	0	2	7	0	73
	Total	14	7	23	20	0	2	7	0	73
3	Peer support meetings, group opportunities*									
	Yes	X		X	X			X	X	
	No		X			X	X			
4	Community consumers providing WRAP training/ peer support:	1	1	0	8	0	3	2	0	15
5	Residents completing WRAP Training	75	19	0	8	0	2	6	31	141

6	Residents completing WRAP Plans	0	7	5	3	0	2	6	6	29
7	Residents employed in community	2	0	4	5	0	0	0	8	19
8	Residents volunteering in community	0	0	20	0	0	2	0	0	22
9	Satisfaction surveys of residents?									
	Yes	X	X	X	X	X	X	X	X	
	No									

*AA or NA meetings not counted

- Employment or meaningful volunteer opportunities provide people in recovery with the satisfaction, self esteem, and confidence that stems from fulfilling socially valued roles. Consumers employed to provide peer support and self-help groups are effective in helping other persons make progress on the road to recovery.
    - Only one hospital (CSH) reported a current hospital resident was employed as a WRAP trainer.
    - The total listed resident-volunteers for all the hospitals (73) are less that 5% of the total hospital census. Three of the hospitals do better with volunteer roles (CAT, ESH, NVMHI), mostly involving work with other hospital residents, such as serving as advocates or representatives, or editing or writing newsletters.
    - Six hospitals reported offering employment opportunities (food service, laundry, etc.) to a total of 243 persons, or about 16% of the total hospital population.
    - Four hospitals (CAT, WSH, ESH, and NVMHI) offered opportunities for 19 persons to experience paid employment in the community near the hospital. Two hospitals (ESH, SVMHI) arranged for 22 persons to provide volunteer services in the community.
    - Analysis of employment and off-campus activities should acknowledge the effects of the physical limitations of geriatric patients at three hospitals (Catawba, ESH, and PGH) and the legal and security limitations of forensic patients at all hospitals, but especially at CSH.
- Hospitals value and are expanding their efforts to provide WRAP training for residents.
    - Five hospitals (Catawba, CSH, NVMHI, SVMHI, and WSH) engage 15 consumers from the community to provide WRAP training on their campuses.
    - 141 residents at six hospitals were involved in WRAP training during the review period with 29 persons completing WRAP plans. CAT, CSH, and WSH had the most activity in this area.

- Many fewer ongoing, consumer-run, peer support groups are being offered than the recovery literature would suggest are desirable. (Sporadic sessions or involvement of persons in other activities were submitted to the OIG, but not accepted as examples of peer-support groups. AA or NA groups also were not counted.) Good examples of such programs include a peer support group run by a community-based consumer on campus at WSH and participation in community self-help groups in the Staunton area for this same hospital. NVMHI contracts with a community drop-in center to send consumers to the hospital to lead employment and computer groups. NVMHI also hosts a number of weekly community advocacy and self-help groups and allows residents to attend. SWVMHI holds Consumer Empowerment Recovery Council meetings each month which are open to all residents.
- Each hospital offers some form of a satisfaction survey for persons served. Many are distributed at the time of discharge, usually with a low response rate. Some are special purpose surveys. None are comprehensive, recovery-focused, and frequent. None are designed or administered by residents.

Section VI

Findings and Recommendations

The findings and recommendations of the OIG related to the recovery experience of individuals served in DMHMRSAS operated mental health facilities are listed below. The descriptive bullets that accompany each finding provide supportive information, but are not intended to include all relevant factors which are included in the body of the report.

Treatment Planning through Partnership

Finding 1: A significant number of persons served in state mental health facilities report that they do not have sufficient input to or influence on the development and documentation of their own goals and treatment plans.

- 31% say they have not had input to their treatment goals and plan, yet 90% of the treatment teams observed occurred with the person present.
- 27% said they have not had a discussion with their treatment team about what will happen after discharge.
- 46% said they have no choice in their treatment plan; 46% said they share decisions about their plan; and 8% say they direct their own care through their treatment plan
- 47% of those interviewed said they agree that their treatment goals in their plan are stated in their own words.
- In 86% of the records reviewed the treatment plan did not incorporate the consumer's own goals in his or her own words.

Finding 2: Residential and PSR staff, family members, friends, and advocates who can assist and support the individual during treatment team meetings are generally not present at these meetings.

- Family members, advocates or other representatives were not present 80% of the time.
- Direct service staff were not present 65% of the time.
- PSR representatives, especially class instructors, were rarely participants in the treatment team meetings.

Finding 3: Representatives from the community who hold a key role in connecting the resident to his home community and planning for discharge are generally not present at treatment team meetings.

- CSB or other community resources were not present in 63% of the observed treatment team meetings.

Finding 4: Treatment team discussions focus primarily on symptoms, behaviors, and medication issues in the hospital – failing to focus on the whole person, the full

treatment/psychosocial experience and the individual's own goals. The individual's treatment plan is generally not central to the treatment team discussion.

- Discussions failed to focus on the actual treatment goals in the treatment plan 65% of the time.
- Usually only one member of the team held a copy of the treatment plan, and the resident did not have a copy to reference.
- Discussions focused on the person's own goals 49% of the time.
- The discussion failed to relate to the person in a holistic way, considering a wide range of life needs and strengths 41% of the time.
- The team talked evaluatively with the consumer's participation about whether or not current daily activities at the hospital are fulfilling and growth producing 38% of the time.
- The team talked about the resident having activities and responsibilities that are appropriate for life outside the facility 32% of the time.
- There was consideration of whether the consumer has a key helping relationship with anyone 28% of the time.
- WSH is the only facility that has created a form ("Self Evaluation Form") that solicits the resident's perspective. WSH treatment team discussions were most often focused on this information.

Finding 5: The leadership provided by the team leader, most often a psychiatrist, is found to be the dominant variable in the degree to which the treatment team meetings reflect recovery values. This leadership varies greatly among the facilities and treatment teams.

- The tone of the meeting and the majority of comments were characterized by hope and positive expectations for recovery 66% of the time.
- Team members used "person first" language in 54% of the treatment teams that were observed.
- The team focused on getting the person out the hospital and back into the community 63% of the time.
- 75% of the time the discussion was truly multi-disciplinary. In others, the team leader dominated the discussion.
- The OIG observed some treatment team meetings at WSH, PGH, NVMHI and SVMHI that were exceptional examples of recovery oriented treatment team meetings.

Finding 6: Record systems reflect a traditional, deficit-based approach to treatment planning and documentation. The record format neither encourages nor facilitates person-centered, person-directed treatment planning. When found at all, which was rare, a person's own concept of goals and plans are an addendum, rather than the central core of the treatment plan.

- 14% of records had goals in the individual's own words or reflecting his or her direct input.
- In 46% of the records was the treatment plan specific and individualized with regard to goals and treatment for life beyond the hospital.

- In 40% of the records did the planning documents relate to a wide variety of life skill/need areas (housing, job, education, social, health, spiritual, etc) reflecting a holistic view of the person.
- 48% of the records showed clear involvement of the consumer with regard to planning for his/her return to the community.
- 4% of the records were judged to use "person first" language.
- Progress being made and the focus of the resident's learning in PSR activities are not central to treatment planning records. When present, the PSR notes are in a separate section of record.

Finding 7: While every hospital provides some consumer feedback opportunities, few were judged to be comprehensive or to give residents a regular, timely opportunity to provide feedback about their satisfaction with treatment and conditions at the hospital.

Choice

Finding 8: Choice, an essential empowering opportunity for persons on the road to recovery, is limited and restricted for the residents in Virginia's state mental health facilities.

- Fundamental civil liberties and opportunities to choose are limited by the fact that 92.6% of Virginia's hospital residents are in an involuntary commitment status. For those committed in a forensic category (30% of the residents) judicial review external to the hospital's clinical decision making is required for certain choices.
- 9.2% of residents are deemed ready for discharge, but are subject to hospital confinement due to a lack of community resources and other external factors.
- 60% of the residents who were interviewed said they have no choice regarding whether to take medications or which medications they will take. 29% said medication decisions were made in partnership with physician.
- Regarding discharge decisions, 63% said they have no choices. 27% said they believe they have no choice about where they will go if discharged.
- Choice is limited in day-to-day activities of resident life:
    - Regarding choice of meals residents reported: 54% no choice, 21% choice of meal is shared with staff, 25% said they make choices about their meals.
    - Residential unit observations by inspectors documented that in 19% of the units was some form of choice in meals offered. Most often this was a person asking that something disliked not be served in the future.
    - About half of residents (52%) said they have a choice of sleep hours.
    - 16% report a choice of room arrangements – choice of room and choice of roommate.
    - While staff were observed offering residents choice in activities of daily living on 61% of observed residential units, this leaves 39% where such choice was not noted, even in such matters as doing laundry, getting ready for dinner, or joining a group for an activity.

Finding 9: The system for granting "privilege levels", a major determinant of the residents' freedom and choice, varies among and even within the mental health hospitals. These systems are often not clearly understood by residents and staff.

- It is not clear what the resident must do to achieve, retain or regain privileges.
- Level of privilege is treated as a physician's order and there are often no provisions for resident, staff or advocate review or appeal.
- At some hospitals, residents are made to wear plastic wristbands that display their privilege level.

Involvement in Valued Roles

Finding 10: Little use of peers to provide support groups, mentoring, or other opportunities to perform valued roles are found in the residential units and PSR classes.

- 25% of the residential units offered some form of valued role for residents. This is mostly limited to participation in unit meeting.
- Residents were observed as peer instructors, class assistants or co-teachers in only 20% of the PSR classes.
- There are, however, good examples:
    - Peer support group run by a consumer from the community and participation by facility residents in community support groups at WSH.
    - NVMHI contracts with a community drop-in center for consumers to lead groups at the facility.
    - SWVMHI monthly Consumer Empowerment Recovery Council meetings open to all residents.

Finding 11: The numbers of individuals who have completed WRAP training and the numbers who have completed personal WRAP plans are very low at the mental health facilities.

- Completed WRAP training - 141 or 9% of total residents.
- Completed WRAP plans - 29 (none at 1 facility).
- Only one current hospital resident is employed as a WRAP trainer at one of the eight facilities (CSH).

Finding 12: Employment and meaningful volunteer opportunities on the facility campus vary significantly across the eight facilities and are very low at some facilities.

- Employed at hospital – 243 or 16% of total residents (less than 5 at 4 facilities, including none at 2 facilities).
- Volunteer on campus – 73 or less than 5% of total residents (CAT, ESH and NVMHI have larger volunteer programs. None at 2 facilities).

Finding 13: Employment and volunteer involvement in the community are quite low.

- Employment in community – 19 (none at 4 facilities)
- Volunteer in community – 22 (none at 6 facilities)

Relationships that Support Recovery

Finding 14: A high percentage of individuals report that there is someone they can trust, relate to and count on at the facility.

- 79% say there is someone they can trust, relate to and count on at the hospital.
    - Doctors 33%
    - Nurses 20%
    - Direct service staff 18%
    - Social workers 18%
    - Other residents 9%
    - Psychologists 5%
    - Other 6%

Finding 15: Facilities do not emphasize or foster the development of supportive connections and helping relationships through programming and treatment.

- It was observed that in 28% of the treatment team discussions was there any consideration of whether the consumer has a key helping relationship with anyone.
- No one staff member (or peer supporter) is assigned to each resident to assure a primary ongoing connection and helping relationship.

Finding 16: Residents report that staff members convey that they have hope for recovery of those they serve.

- 80% of residents agreed with the statement "Staff at this hospital believe that I can grow, change and recover."
- 84% answered yes when asked "Do the staff believe that your mental health condition will improve?"

Finding 17: Major gaps exist in staff knowledge and attitudes about recovery-based treatment.

- Staff has a fairly accurate understanding of the importance of a positive self-identity for individuals apart from the illness and the importance of peer support in the recovery process - *Roles of Self-Definition and Peers in Recovery*. However, there is an inaccurate understanding of the role of professionals in encouraging individuals to take risks.
- Staff has a good understanding of the different roles of staff and persons in recovery - *Roles and Responsibilities in Recovery*,
- Staff does not have an accurate understanding of who is capable of participating in recovery and the effect of creating expectations for individuals in recovery - *Expectations Regarding Recovery*.
- Staff does not have an accurate understanding of the path of recovery -*Non-linearity of the Recovery Process*. The majority seems to think that recovery is only for those less sick, more compliant and non-symptomatic – that it is a straight path without relapses and setbacks.

Finding 18: There are indications from residents that staff may not value or be adequately respectful of their opinions and perspectives.

- 32% of residents disagreed with each of these statements: "Most staff listen carefully to what I have to say" and "Most staff understand my experience as a person with mental illness."
- 42% of respondents disagreed with the statement "Staff see me as an equal partner in my treatment program."
- 40% agreed with the statement "Staff interfere with my personal relationships."
- 39% agreed with the statement "Staff have used pressure, force or threats in my treatment."
- 35% disagreed with the statement "I feel have a say in the treatment I get here."

Finding 19: "Person first" language is not consistently used by staff.

- Used 57% of time in PSR.
- Used 54% of time in treatment team meetings.
- Used only in 4% of the records.

Providing a Supportive Environment for Recovery

Finding 20: Staff interactions with residents in PSR classes are generally positive and appropriate.

- Respectful and courteous - 99% of the time.
- Effort made to involve and engage all consumers, except those who clearly refused to participate – 95% of the time.
- Warm, accepting and welcoming – 95% of the time.
- Residents encouraged to do what they could for themselves rather than staff doing most things for them without checking – 96% of the time.

Finding 21: Staff interactions with residents in the residential units are inconsistent across the eight hospitals, but most often inadequate to foster a recovery environment in activities of daily living, leisure time use, and stimulation of interests.

- Most staff were making an effort to involve and engage consumers on only 47% of the residential units. On 53% of the units there was no significant interaction taking place between residents and staff.
- It was common for staff to sit or stand around the unit office instead of mixing with residents. At one hospital, staff reported that they were told not to interact with residents because this would distract them from their primary mission – assuring that no accidents occur.
- When staff did interact with residents, the interactions were:
    - Respectful and courteous – 92% of the time.
    - Warm, accepting and welcoming – 88% of the time.

Finding 22: Most residential units lack supplies, resources and activities to enable residents to develop and engage in interests, learn about recovery, pass time productively and avoid boredom.

- 42% of the units had some magazines, books and games available. Most were out of date, incomplete, tattered or dull. When newer supplies were available, they were kept under lock and key.
- More than half (58%) had nothing available.
- TV's blared incessantly, often with no viewers.
- While all facilities have good libraries, access is very limited due to schedules and the privilege system.
- 15% of the units had posters, brochures, books or videotapes on mental illness, medication, recovery or wellness available. CAT stood out in posting material about recovery.
- 13% of the units provided reasonable access to a computer with internet service.

Finding 23: The physical environment of many residential unit common spaces, bedrooms and bathrooms lack warmth, comfort, attractiveness and privacy.

- Quiet places to read, relax and be alone are hard to find in 49% of the residential units that were observed.
- Few private bedrooms exit.
- Furnishings were rated as comfortable and pleasant 51% of the time.
- In 36% of the units there are no doors or curtains for showers.
- Over half of residents (53%) must take meals in the same space where they spend most of their time – on the living unit.

Finding 24: A significant number of individuals in the mental health hospitals say that they do not feel safe in the facility. This factor greatly limits the individual's progress in recovery.

- 25% say they do not feel safe.
- The expressed concern is safety from peers, not staff.
- 30% agree with the statement "Services at this hospital have caused me emotional or physical harm."

Recommendations

Recommendation 1: It is recommended that each mental health facility develop and implement a Comprehensive Facility Plan on Recovery. The purpose of this plan will be to enhance the extent to which the experience of those individuals who are served reflects the principles of recovery, self-determination, person-centered planning, and choice. The plan should identify specific measures that will be used to assess progress, be completed no later than August 30, 2007, and address:

- The role of senior leadership
- Workforce development
- Treatment planning

- Design of the clinical record
- Resident activities and opportunities
- Relationship to the community
- Other areas as determined relevant to enhancing the recovery experience of those who are served by the facility.

DMHMRSAS Response: *DMHMRSAS accepts the recommendation of the Inspector General. The Assistant Commissioner for Facility Management will have each mental health facility develop and implement a Comprehensive Facility Plan on Recovery. The purpose of this plan will be to enhance the extent to which the experience of those individuals who are served reflects the principles of recovery, self-determination, person centered planning and choice. The plan will identify specific measures that will be used to assess progress. The plan will address:*

- *The role of senior leadership*
- *Workforce development*
- *Treatment planning*
- *Design of the clinical record*
- *Resident activities and opportunities*
- *Relationship to the community*
- *Other areas ad determined relevant to enhancing the recover experience of those who are served by the facility*

The plans will be completed and submitted to your office, by the Office of Facility Operations no later than August 30, 2007.

Recommendation 2: It is recommended that each facility prepare a semiannual report that provides an update on progress toward all aspects of the Comprehensive Facility Plan on Recovery and that this report is submitted to the OIG no later than the end of February and August of each year in 2008 and 2009.

DMHMRSAS Response: *The Assistant Commissioner for Facility Management at DMHMRSAS will ensure a semiannual report which provides an update on progress towards all aspect of the Comprehensive Facility Plan on Recovery will be submitted to the OIG no later than the end of February and August of each year in 2008 and 2009.*

Section VII

Appendix

A. SAMSHA National Consensus Statement on Mental Health Recovery

B. Survey Questionnaires/Checklists and Results of these Instruments
(Documents are available in the website version of this report found at www.oig.virginia.gov)

Hospital Unit Observation Checklist
Hospital Unit Observation Data

PSR Activity Observation Checklist
PSR Activity Observation Data

Consumer Interview Checklist
Consumer Interview Data

Record Review Checklist
Record Review Data

Staff Interview Checklist
Staff Interview Data

Treatment Team Observation Checklist
Treatment Team Data

Appendix A

SAMSHA National Consensus Statement on Mental Health Recovery:

1. **Self-Direction**: Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.
2. **Individualized and Person-Centered**: There are multiple pathways to recovery based on an individual's unique strengths and resiliencies, as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result, as well as an overall paradigm for achieving wellness and optimal mental health.
3. **Empowerment**: Consumers have the authority to choose from a range of options and to participate in all decisions, including the allocation of resources that will affect their lives, and are educated and supported in doing so. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.
4. **Holistic**: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services (such as recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.
5. **Non-Linear**: Recovery is not a step-by step process, but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.
6. **Strengths-Based**: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

7. **Peer Support**: Mutual support, including the sharing of experiential knowledge and skills and social learning, plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.
8. **Respect**: Community, systems, and societal acceptance and appreciation of consumers, including protecting their rights and eliminating discrimination and stigma, are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.
9. **Responsibility**: Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
10. **Hope**: Recovery provides the essential and motivating message of a better future- that people can and do overcome the barriers and obstacles that confront them. Hope is internalized, but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.

Appendix B

Hospital Unit Observation Checklist

Name of Hospital: _____
Date: _____

Type of Activity Observed: Unit:_____ Time:_____
Activity:_____

1. Did most staff interact with the consumers in a respectful, courteous manner?
   yes_____ no_____comment:

2. Did most staff make an effort to involve and engage all consumers, excepting those who clearly refused to participate after being invited?
   yes_____ no_____comment

3. Were most staff interactions warm, accepting, and welcoming to consumers?
   yes_____ no_____comment

4. Did most staff seek to offer consumers choice on all matters possible?
   yes_____ no_____comment

5. Did the consumers have access to the following (on the unit, reasonable access – not across campus at limited hours)

   telephone(s) yes_____ no_____comment

   snack or drink machines yes_____ no_____comment (limits?)

   computer with internet access yes_____ no_____comment(limits?)

6. Were there interesting options available for consumer choice for self-directed activities? (e.g., games, books, videotapes, etc.) (on the unit, reasonable access – not across campus at limited hours)
   yes_____ no_____comment

7. Was there any evidence (seen or reported) of consumers filling valued roles in unit life (e.g., peer support, unit governance, leading meetings, etc.)
   yes_____ no_____comment

8. Are meals typically served in a dedicated dining room, off the unit, or, at least, not in the day activity/living area?
   yes_____ no_____comment

9. Do residents have choice of what they eat at meals?
   yes_____ no_____comment

10. Was there a place where consumers could enjoy private, quiet time, to read, for example, other than the day room or their bedroom?
    yes_____ no_____comment

11. Was the unit furnished with comfortable, pleasant, “homey” furnishings (e.g., furniture, carpeting, curtains, wall décor, etc.)?
    yes_____ no_____comment

12. Were consumers able to decorate their own rooms in their own style? Or, at least, were the rooms decorated at all (curtains, prints, posters, rug, etc.), if not by the resident himself/herself?
    yes_____ no_____comment

13. Did the consumers have privacy?

    in sleeping arrangements (e.g., a private room or choice of having a roommate) If some are private and some double or triple, assignment to a roommate rather than choice, rates a "no."
    yes_____ no_____comment

    in toilet and bathing facilities? (doors that close – not curtains - for commodes).
    yes_____ no_____comment

14. Were there any books, videotapes, brochures, posters on recovery-relevant topics (mental illness information, WRAP plans), medication information, etc. – rather than simply entertainment) (on the unit, reasonable access – not across campus at limited hours).
    yes_____ no_____comment

15. Did the staff encourage residents to do what they could for themselves, rather than doing most things for them without checking?
    yes_____ no_____comment

16. Did most staff use recovery-oriented language? (per META services)
    yes_____ no_____comment

Unit Observation:

	Q1		**Q2**		**Q3**		**Q4**		**Q5a**		**Q5B**		**Q5C**	
	respect & courtesy		**engage**		**warm, accepting**		**choice**		**telephone**		**snack**		**computer**	
Facility	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No
All Eight MH Facilities Combined %	92	8	47	53	88	12	61	39	99	1	61	39	13	87
Catawba	100	0	100	0	100	0	100	0	100	0	0	100	50	50
CSH	91	9	45	55	82	18	45	9	91	9	73	27	0	100
ESH	84	16	12	80	76	20	12	60	100	0	68	32	4	88
NVMHI	100	0	40	60	100	0	60	0	100	0	100	0	100	0
PGH	100	0	80	20	100	0	20	0	100	0	80	20	0	100
SVMHI	100	0	25	25	75	0	75	0	100	0	75	25	0	100
SWVMHI	100	0	83	17	100	0	50	17	100	0	17	83	0	100
WSH	91	9	64	27	82	9	55	9	100	0	45	55	9	91
N (Total Responses)	71		66		68		46		71		71		69	

	Q6		Q7		Q8		Q9		Q10		Q11		Q12	
	games/books		valued role		dining room		meal choice		quiet place		"homey"		decorated rooms	
Facility	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No
All Eight MH Facilities Combined %	42	58	25	75	47	53	19	81	51	49	44	56	53	47
Catawba	0	100	25	75	50	50	100	0	75	25	50	50	50	50
CSH	18	82	0	100	64	36	36	64	55	45	18	82	18	82
ESH	12	84	12	84	20	80	8	88	36	64	36	64	56	48
NVMHI	80	20	100	0	100	0	0	100	60	40	80	20	60	40
PGH	80	0	60	20	40	60	40	60	80	20	80	20	80	20
SVMHI	100	0	75	25	100	0	25	75	50	50	100	0	100	0
SWVMHI	50	50	17	83	83	0	0	83	0	100	17	83	33	67
WSH	82	18	9	91	27	73	0	100	82	9	45	55	64	36
N (Total Responses)	69		69		70		69		70		71		72	

	Q13A		Q13B		Q14		Q15		Q16	
	privacy (sleeping)		privacy (bath, toilet)		MH educ.materials		residents do for themselves		recovery language	
Facility	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No
All Eight MH Facilities Combined %	12	88	64	36	15	85	78	22	19	81
Catawba	0	100	0	75	25	75	100	0	50	25
CSH	0	91	91	9	0	100	64	0	0	91
ESH	12	84	56	44	0	100	24	40	4	56
NVMHI	0	100	100	0	0	100	100	0	40	20
PGH	0	100	0	80	80	20	60	0	40	0
SVMHI	0	100	100	0	100	0	100	0	0	0
SWVMHI	0	100	100	0	0	100	100	0	0	67
WSH	45	55	45	55	0	0	0	0	0	0
N (Total Responses)	69		69		60		45		37	

Office of the Inspector General
for Mental Health, Mental Retardation, and Substance Abuse Services

Review of Services at Virginia State Mental Health Facilities

PSR Activity Observation Checklist

Name of Hospital: _____
Date: _____
Type of Activity Observed: Class:_____ Time:_____

1. Did the staff typically interact with the consumers in a respectful, courteous manner?
   yes ____no ____ comment:

2. Did the staff typically make an effort to involve and engage all consumers, excepting only those who clearly refused to participate after being invited?
   yes ____no ____ comment:

3. Was most staff interaction with consumers warm, accepting, and welcoming?
   yes ____no ____ comment:

4. Did the staff seek to offer consumers choice on all matters possible (not usually evident in a lecture or discussion class, more likely in an activity class)?
   yes ____no ____ NA____ (classroom presentation, choice not applicable)
   comment:

5. Was there class involvement of a peer instructor, class assistant, etc. – was any consumer performing a valued role?
   yes ____no ____ comment:

6. Was the class conducted in an age-appropriate, learning-oriented manner?
   yes ____no ____ comment:

7. Was their good attendance? (80 % of enrolled students) Ask the instructor or look at attendance rosters.
   yes ____ no ____ comment:

8. Did the instructor know why absent persons were not there and where they were?
   yes ____no ____ comment

9. Were there people wandering the halls or lounging in the canteen, library, etc. at class times (not break times)?
   yes ____no ____ comment

10. Did the staff encourage residents to do what they could for themselves, rather than doing most things for them without checking? (This is more relevant for activity classes, rather than lecture or discussion classes).
    yes_____ no_____NA____ comment

11. Were the majority of the class members engaged, interested, and attending to the session (rather than bored, not listening, etc.)
    yes_____ no_____NA____ comment

12. Did most staff use recovery-oriented language? (per META services)
    yes_____ no_____comment

PSR Activity:

	Q1		Q2		Q3		Q4		Q5	
	respectful, courteous manner		involve and engage all		warm, accepting, welcoming		offer choices on all matters possible		involvement of peer instructor, assistant - consumer in valued role	
Facility	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No
All Eight MH Facilities Combined %	99	1	95	5	95	5	98	2	20	80
Catawba	100	0	100	0	100	0	82	0	36	64
CSH	100	0	90	5	86	14	48	5	19	76
ESH	100	0	71	21	100	0	57	0	14	79
NVMHI	100	0	90	0	90	10	70	0	10	80
PGH	100	0	100	0	100	0	100	0	20	80
SVMHI	100	0	100	0	100	0	75	0	0	100
SWVMHI	100	0	100	0	100	0	100	0	27	73
WSH	91	9	100	0	91	9	64	0	27	73
N (Total Responses)	91		88		91		64		88	

	Q6		Q7		Q8		Q9		Q10		Q11		Q12	
	age-appropriate, learning-oriented		good attendance (80%)		why absent not there & where		wandering		encourage to do for themselves		engaged, interested		use recovery-oriented language	
Facility	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No
All Eight MH Facilities Combined %	97	3	76	24	83	17	21	79	96	4	91	9	57	43
Catawba	100	0	100	0	91	0	0	100	83	0	91	0	64	0
CSH	100	0	67	29	48	5	19	81	62	0	76	19	24	43
ESH	86	7	43	43	50	36	14	79	43	14	79	21	36	50
NVMHI	90	10	60	10	10	20	30	40	60	0	100	0	40	10
PGH	100	0	20	0	80	0	0	100	100	0	100	0	40	40
SVMHI	88	13	25	75	38	38	100	0	50	0	100	0	50	13
SWVMHI	100	0	73	0	82	0	9	82	100	0	100	0	27	27
WSH	100	0	100	0	91	0	0	91	0	0	0	0	0	0
N (Total Responses)	90		78		65		85		56		78		53	

Office of the Inspector General
for Mental Health, Mental Retardation, and Substance Abuse Services

Review of Services at Virginia State Mental Health Facilities

Consumer Interview

Name of Hospital: _____

Section A.
Information about you

1. What is your gender? Male Female

2. What is you age? ____

3. Do you feel that you have had input to your treatment goals? Has the treatment team involved you in making your plan?

   yes no not sure, do not know

4. Have you and the treatment team (or other staff you work with) had a discussion about what it will take for you to be able to leave the hospital and avoid having to come back again?

   yes no not sure, do not know

5. What is it about the care you receive at this hospital that helps you the **most**?

6. What is it about the care you receive at this hospital that helps you the **least**?

7. Do *you* believe that your mental health condition will improve – that you will get better?

   yes no not sure, does not apply to me

8. Do you think the *staff* here at this hospital believe your mental health condition will improve – that you will get better?

   yes no not sure, does not apply to me

9. Is there someone – anyone - at this hospital you can count on most to help you? Someone that you really trust and relate to, and talk to?

   yes no

10. If the answer to question number 9 is yes, who is that person?
    If there are more than one, pick the **one** who helps the most. ***Circle only one***:

    doctor

    nurse

    social worker

aide or DSA

psychologist

another patient

other (please describe)_____

11. What choices do you get to make at this hospital – what are the things that **you** get decide or **help** decide? Circle the ones that apply to you:

What I eat at mealtime	I decide	no choice	shared decision
When I go to sleep or wake up	I decide	no choice	shared decision
Whether I share a room and with whom	I decide	no choice	shared decision
What I wear each day	I decide	no choice	shared decision
What is in my treatment plan	I decide	no choice	shared decision
What classes I take at the at the treatment mall	I decide	no choice	shared decision
Whether I take medications and which ones.	I decide	no choice	shared decision
When I will be ready to leave the hospital	I decide	no choice	shared decision
Where I will go when I leave the hospital	I decide	no choice	shared decision

12. Do you feel the rules about your "level' – grounds privileges, etc. – are fair and fairly administered?

yes no not sure, mixed opinion

13. Do you feel the pending/proposed smoking rules at this hospital are appropriate?

yes no not sure, mixed opinions

14. Do you like the food served at the hospital?

yes no not sure, mixed opinion

15. Do you feel safe at this hospital?

yes no not sure, mixed opinion

If your answer on the question above is "no," Who do think might harm you?

staff other patients both

Section B Your Experience of Recovery-Oriented Treatment

Put an X in the box that is your choice

Statements - Put an X in the box that best represents your situation while receiving care at this hospital	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**	**Does Not Apply to Me, (or Not Sure, or Mixed Answer)**
1. Most staff at this hospital listen carefully to what I have to say.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply to Me, not sure, mixed opinion
2. Most staff at this hospital see me as an equal partner in my treatment program.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply to Me, not sure, mixed opinion
3. .Most staff at this hospital treat me with respect and courtesy.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply to Me, not sure, mixed opinion
4. Most staff at this hospital understand my experience as a person with mental health problems.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply to Me, not sure, mixed opinion
5. Most staff at this hospital help me to become more independent.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply to Me, not sure, mixed opinion
6. I feel I have a say in the treatment I get here.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply to Me, not sure, mixed opinion
7. Staff at this hospital have used pressure, threats, or force in my treatment.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply to Me, not sure, mixed opinion
8. Staff at this hospital help me learn how to take care of my own health and mental health.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply to Me, not sure, mixed opinion
9. The doctor has worked with me to get me on medications that are most helpful to me.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply to Me, not sure, mixed opinion
10. Staff at this hospital pay attention to my physical health needs.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply to Me, not sure, mixed opinion
11. Most staff at this hospital have up-to-date knowledge on the most effective treatments for mental illness.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply to Me, not sure, mixed opinion, not sure, mixed opinion

12. Staff at this hospital interfere with my personal relationships.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply to Me
13. Services at this hospital have caused me emotional or physical harm.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply to Me, not sure, mixed opinion
14. There is at least one person at this hospital who believes in me.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply to Me, not sure, mixed opinion
15. Staff at this hospital treat me with respect regarding my cultural background (race, language, etc.)	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply to Me, not sure, mixed opinion
16. Staff at this hospital believe that I can grow, change, and recover.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply to Me, not sure, mixed opinion
17. My treatment goals (in my treatment plan) are stated in my own words.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply to Me, not sure, mixed opinion
18. There is a consumer or peer support person I can turn to when I need one.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply to Me

Section C
Comments

Please make any suggestions you think would improve the care you receive at this hospital.

Consumer Interview:

	Q3		Q4		Q7		Q8		Q9		Q11A		
	input to trt.plan		plan with staff to leave hospital		person has hope		staff have hope		someone to relate to		meals		
Facility	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	I decide	No choice	Shared
All Eight MH Facilities Combined %	69	31	73	27	91	9	84	16	79	21	25	54	21
Catawba	74	13	78	17	100	0	64	19	73	27	35	48	17
CSH	66	28	66	17	74	11	70	9	79	15	38	17	30
ESH	62	30	62	31	70	13	70	13	73	20	10	67	16
NVMHI	43	43	79	14	82	4	75	14	61	32	32	29	32
PGH	41	48	37	52	0	0	0	0	0	0	19	59	19
SVMHI	88	6	71	24	94	6	76	0	88	6	24	53	24
SWVMHI	69	16	69	22	56	0	47	16	59	13	16	72	13
WSH	65	31	75	20	78	6	67	16	75	24	29	49	14
N (Total Responses)	284		285		199		192		222		292		

	Q11B			Q11C			Q11D			Q11E		
	sleep/wake			share room			clothes			what is in trt. Plan		
Facility	I decide	No choice	Shared	I decide	No choice	Shared	I decide	No choice	Shared	I decide	No choice	Shared
All Eight MH Facilities Combined %	52	31	17	16	69	15	80	17	3	8	46	46
Catawba	65	22	13	26	43	26	100	0	0	0	30	70
CSH	28	23	32	11	47	23	70	6	4	2	36	43
ESH	45	30	17	16	64	10	54	38	2	8	46	34
NVMHI	50	25	14	0	79	11	86	4	4	4	46	46
PGH	56	30	0	15	67	0	56	26	7	11	33	41
SVMHI	71	18	12	12	65	24	100	0	0	12	29	53
SWVMHI	56	34	3	3	66	3	88	13	0	3	47	44
WSH	43	33	16	25	55	12	86	4	2	16	45	33
N (Total Responses)	284			273			289			282		

	Q11F			Q11G			Q11H			Q11I		
	classes @ PSR			take/choose meds			ready to leave			where to go		
Facility	I decide	No choice	Shared	I decide	No choice	Shared	I decide	No choice	Shared	I decide	No choice	Shared
All Eight MH Facilities Combined %	25	37	38	11	60	29	10	63	28	37	27	35
Catawba	35	13	52	0	39	61	0	43	57	48	9	30
CSH	17	28	38	15	40	30	13	43	30	38	19	30
ESH	15	38	31	8	63	22	9	66	18	30	24	30
NVMHI	29	25	36	21	46	32	11	39	43	11	21	57
PGH	33	44	4	4	74	19	15	59	11	33	33	19
SVMHI	12	35	47	24	41	35	6	47	47	35	18	47
SWVMHI	22	47	25	6	78	16	3	88	6	31	44	19
WSH	29	27	39	12	59	25	10	63	25	41	24	31
N (Total Responses)	277			296			291			278		

	Q12		Q13		Q14		Q15	
	rules/level fair		smoke		food		safe	
Facility	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No
All Eight MH Facilities Combined %	70	30	58	42	65	35	75	25
Catawba	55	27	64	9	82	18	78	9
CSH	53	28	38	38	51	36	68	19
ESH	57	21	50	20	50	23	61	28
NVMHI	57	21	50	25	68	4	61	21
PGH	0	0	0	0	0	0	67	22
SVMHI	71	12	59	24	65	6	88	6
SWVMHI	47	13	22	41	34	16	78	13
WSH	45	31	39	39	37	51	71	22
N (Total Responses)	185.0		178.0		186.0		287.0	

	Statement 1				Statement 2				Statement 3			
	listen to me				equal partner				treats with respect, courtesy			
Facility	% Strongly Disagree	% Disagree	% Agree	% Strongly Agree	% Strongly Disagree	% Disagree	% Agree	% Strongly Agree	% Strongly Disagree	% Disagree	% Agree	% Strongly Agree
All Eight MH Facilities Combined %	9	23	57	11	19	23	47	11	7	15	63	15
Catawba	9	17	52	22	18	27	45	0	0	9	57	26
CSH	17	13	45	21	11	19	45	13	13	17	45	19
ESH	9	28	53	5	21	23	38	11	8	17	51	11
NVMHI	4	25	54	14	29	18	32	18	7	4	64	21
PGH	7	22	67	0	0	0	0	0	0	19	70	4
SVMHI	0	12	71	18	6	0	65	18	6	12	53	24
SWVMHI	0	13	75	9	3	6	47	3	0	6	78	13
WSH	10	33	43	8	22	33	35	6	10	16	65	4
N (Total Responses)	299				213				288			

	Statement 4				Statement 5				Statement 6			
	understand my experience				help to become independent				I have a say in treatment			
Facility	% Strongly Disagree	% Disagree	% Agree	% Strongly Agree	% Strongly Disagree	% Disagree	% Agree	% Strongly Agree	% Strongly Disagree	% Disagree	% Agree	% Strongly Agree
All Eight MH Facilities Combined %	12	20	56	12	7	24	54	14	14	21	52	12
Catawba	0	36	18	18	0	30	35	26	18	18	55	9
CSH	15	15	49	6	6	23	43	19	13	23	47	11
ESH	9	13	45	14	13	28	39	9	21	16	39	11
NVMHI	14	7	46	14	0	32	46	14	18	21	43	18
PGH	0	0	0	0	4	19	59	0	0	0	0	0
SVMHI	0	12	65	18	6	6	47	29	0	6	59	24
SWVMHI	6	9	50	6	3	3	72	13	0	19	47	3
WSH	12	29	47	6	8	22	59	8	10	22	49	8
N (Total Responses)	203				282				214			

	Statement 7				Statement 8				Statement 9			
	staff use pressure, threats 7 force				staff helps me learn to care for self				doctor works with me on meds			
Facility	% Strongly Disagree	% Disagree	% Agree	% Strongly Agree	% Strongly Disagree	% Disagree	% Agree	% Strongly Agree	% Strongly Disagree	% Disagree	% Agree	% Strongly Agree
All Eight MH Facilities Combined %	20	41	30	9	8	23	56	14	9	19	55	17
Catawba	35	43	17	0	0	18	73	9	4	13	48	35
CSH	30	28	21	13	6	23	43	17	9	17	40	21
ESH	11	40	30	13	7	14	46	18	9	18	47	15
NVMHI	21	29	43	4	4	25	57	14	7	21	36	32
PGH	19	59	15	0	0	0	0	0	7	26	52	4
SVMHI	53	35	6	0	6	6	65	24	0	0	76	18
SWVMHI	3	41	41	6	0	28	38	3	6	16	63	6
WSH	14	39	33	12	14	20	51	2	10	18	53	6
N (Total Responses)	294				212				282			

	Statement 10				Statement 11				Statement 12			
	pay attention to physical health				staff up to date				staff interferes in my personal relationships			
Facility	% Agree	% Strongly Agree	% Strongly Disagree	% Disagree	% Agree	% Strongly Agree	% Strongly Disagree	% Disagree	% Agree	% Strongly Agree	% Strongly Disagree	% Disagree
All Eight MH Facilities Combined %	55	17	10	16	56	19	9	23	51	17	17	44
Catawba	48	35	0	18	64	18	9	9	36	9	9	55
CSH	40	21	9	6	55	23	6	23	34	19	15	36
ESH	47	15	13	13	46	18	11	13	45	16	18	27
NVMHI	36	32	11	14	43	25	7	29	39	25	11	50
PGH	52	4	0	0	0	0	0	0	0	0	0	0
SVMHI	76	18	6	6	65	24	6	6	53	18	35	24
SWVMHI	63	6	0	19	41	13	0	6	50	9	3	44
WSH	53	6	14	22	51	6	8	29	39	4	12	35
N (Total Responses)	218				197				200			

	Statement 13				Statement 14				Statement 15			
	services cause emotional/phys .harm				at least one person believes in me				treat with respect for cultural background			
Facility	% Strongly Disagree	% Disagree	% Agree	% Strongly Agree	% Strongly Disagree	% Disagree	% Agree	% Strongly Agree	% Strongly Disagree	% Disagree	% Agree	% Strongly Agree
All Eight MH Facilities Combined %	17	53	22	8	4	14	60	22	10	13	58	19
Catawba	17	57	13	4	0	26	43	26	0	9	91	0
CSH	21	34	21	13	0	4	66	23	15	6	47	28
ESH	10	54	18	8	6	21	46	15	7	16	46	14
NVMHI	32	36	18	7	4	11	54	29	7	14	39	29
PGH	15	59	19	0	4	11	59	7	0	0	0	0
SVMHI	29	41	12	0	6	0	41	35	6	12	47	35
SWVMHI	3	59	25	3	3	6	69	16	0	6	50	6
WSH	10	39	27	12	2	14	59	20	12	12	57	6
N (Total Responses)	281				283				209			

	Statement 16				Statement 17				Statement 18			
	staff believe I can change				my goals are in my own words				I have peer support			
Facility	% Strongly Disagree	% Disagree	% Agree	% Strongly Agree	% Strongly Disagree	% Disagree	% Agree	% Strongly Agree	% Strongly Disagree	% Disagree	% Agree	% Strongly Agree
All Eight MH Facilities Combined %	5	15	61	19	14	39	39	8	10	21	48	20
Catawba	0	22	39	26	9	55	18	0	9	18	27	27
CSH	4	15	49	23	13	26	36	13	11	21	32	28
ESH	10	15	46	9	16	29	25	9	14	18	36	14
NVMHI	0	7	50	32	21	36	29	7	11	14	43	18
PGH	0	26	63	4	0	0	0	0	0	0	0	0
SVMHI	6	0	53	41	0	29	53	6	12	6	53	29
SWVMHI	0	9	69	16	3	44	13	0	0	13	41	9
WSH	6	8	63	8	10	25	41	2	4	24	51	8
N (Total Responses)	273				194				203			

Office of the Inspector General
for Mental Health, Mental Retardation, and Substance Abuse Services

Review of Services at Virginia State Mental Health Facilities

Record Review

Name of Hospital: _____

Name of consumer being reviewed: _____

1. Does the treatment plan (including the treatment planning team reviews and updates and other materials in the treatment planning section of the record, but not information from other sections) meaningfully elicit and incorporate the consumer's own goals, in his or her own words? Is treatment at least *partly* based on the consumer's stated wishes and preferences.

Yes No NA Comment:

2. Was the consumer present at most treatment team meetings (e.g., initial, periodic Treatment Planning Conferences? (75% attendance over all meetings in the last 90 days?

Yes No Comment:

3. Does the documentation show that the consumer actively participated in the TPC, or that the TPC made efforts to facilitate meaningful participation?

Yes No Comment:

4. Was there a family member, friend, or advocate (peer, CSB representative, human rights advocate, etc. – preferably someone chosen for this role by the consumer) present at any of the planning meetings?

Yes No Comment:

5. Is the treatment plan specific and individualized with regard to goals and treatment that will help the consumer move out of the facility and enjoy a satisfying, good life in the community? (e.g., Is it a plan for life beyond the hospital, rather than just a focus on stabilization of symptoms, eradication of behaviors, etc.)

Yes No NA Comment:

6. Do the treatment planning documents relate to a wide variety of life skill/need areas (housing, job, education, social, health, spiritual, etc) – showing an holistic view of the person, rather than a focus only on symptoms and behavior change? See treatment plan, social work, check psychology and PSR notes.

Yes No NA Comment:

7. Does record show clear involvement of the consumer with regard to his or her return to the community? Is discharge planning dialogue (with CSB liaison, community resources, etc.) "with" the person, rather than "about" the person?

Yes No Comment:

8. Is the hospital providing education for the patient to become empowered, hopeful, and engaged in dealing with his own illness, symptoms, medications/side effects, relapse prevention, etc. (Not just "med-ed," but a real focus on helping the consumer become a partner in charting his own recovery.) Check PSR class list.

Yes No Comment:

9. Did the consumer receive an assessment of co-occurring substance abuse treatment needs?

Yes No Comment:

10. If substance abuse needs are identified, is treatment addressing co-occurring MI/SA needs? (if no SA needs are identified in #9, check N.A.)

Yes No N.A. Comment:

11. Does the hospital provide training in self help and community skills that are responsive to this person's perceived deficits and/or need to fulfill life plans or goals? (check treatment plan and PSR classes – do they relate to the documented goals, skill deficits, etc.?)

Yes No Comment:

12. Can the record be generally characterized as showing respectful, accepting, supportive, and non-judgmental treatment? (Shows a person who may *have* problems, rather that a person who *is* a problem)

Yes No Comment:

13. Can the record be generally characterized as using person-first language? (This is specific to the language used. Is it non-stigmatizing, non-labeling, not "directive" and not "old fashioned medical model"? Does it say "will be compliant," for example.)

Yes No Comment:

:

Record Review:

	Q1		Q2		Q3		Q4		Q5		Q6		Q7	
	own goals in own words		present @ TT		participate in TT		adv/family @ TT		out into community		holistic		involved in D/C plan	
Facility	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No
All Eight MH Facilities Combined %	14	86	81	19	48	52	29	71	46	54	40	60	48	52
Catawba	0	100	30	70	9	91	4	96	74	22	17	52	26	74
CSH	8	86	88	12	45	55	43	57	10	67	6	69	24	76
ESH	7	82	68	31	21	77	17	82	25	38	23	33	32	60
NVMHI	14	86	96	4	61	36	18	79	57	32	71	18	89	11
PGH	0	93	100	0	22	78	44	56	56	44	41	56	37	63
SVMHI	19	69	94	6	88	13	63	38	38	56	31	63	75	25
SWVMHI	3	97	97	3	91	9	16	84	50	38	44	41	41	59
WSH	47	53	81	17	77	21	40	60	43	49	36	53	77	19
N (Total Responses)	298		313		311		313		259		242		306	

	Q8		Q9		Q10		Q11		Q12		Q13	
	learn about illness		**MI/SA assess**		**MI/SA services**		**training relate to needs on TP**		**respect, non-judgmental**		**person first, recovery**	
Facility	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No
All Eight MH Facilities Combined %	61	39	88	12	69	31	89	11	98	2	4	96
Catawba	30	70	96	4	4	17	91	9	100	0	0	100
CSH	82	18	90	8	65	4	71	39	100	0	0	100
ESH	28	52	84	15	26	11	80	13	93	7	1	99
NVMHI	86	11	96	4	32	18	96	4	96	0	43	57
PGH	19	81	44	56	4	19	89	11	100	0	0	100
SVMHI	100	0	100	0	25	0	100	0	100	0	0	100
SWVMHI	66	34	91	9	28	13	91	6	100	0	0	100
WSH	75	17	98	2	30	23	94	4	98	2	2	98
N (Total Responses)	292		313		137		307		314		315	

Office of the Inspector General
for Mental Health, Mental Retardation, and Substance Abuse Services

Review of Services at Virginia State Mental Health Facilities

Staff Interview

Name of Hospital: _____

Section A. Information about you

1. How long have you worked at this hospital? ____ years (round to nearest year)

2. What is your job?

Program Staff

Direct Service Provider (DSA, Aide, Psych Tech, PSR Tech, etc.)		_____
Nurse		_____
Social Worker		_____
Psychologist	_____	
Rehabilitation Therapist (OT,PT, etc.)	_____	
Psychiatrist	_____	
Supervisor of one of these staff roles (e.g., nurse manager, unit mgr, soc work director)	_____	

Administrative Staff

Executive Team		_____
Other Administrative Staff (e.g., clerical, support, maintenance, driver, etc.)	_____	
Other (please state_____)	_____	

Section B
Staff Survey (circle one)

1. The concept of recovery is equally relevant to all phases of treatment.
Strongly Disagree DisagreeNot SureAgree Strongly Agree

2. People receiving psychiatric/substance abuse treatment are unlikely to be able to decide their own treatment and rehabilitation goals.
Strongly Disagree DisagreeNot SureAgree Strongly Agree

3. All professionals should encourage clients to take risks in the pursuit of recovery.
Strongly Disagree DisagreeNot SureAgree Strongly Agree

4. Symptom management is the first step toward recovery from mental illness/substance abuse.
Strongly Disagree DisagreeNot SureAgree Strongly Agree

5. Not everyone is capable of actively participating in the recovery process.
Strongly Disagree DisagreeNot SureAgree Strongly Agree

6. People with mental illness/substance abuse should not be burdened with the responsibilities of everyday life.
Strongly Disagree DisagreeNot SureAgree Strongly Agree

7. Recovery in serious mental illness/substance abuse is achieved by following a prescribed set of procedures.
Strongly Disagree DisagreeNot SureAgree Strongly Agree

8. The pursuit of hobbies and leisure activities is important for recovery.
Strongly Disagree DisagreeNot SureAgree Strongly Agree

9. It is the responsibility of professionals to protect their clients against possible failures and disappointments.
Strongly Disagree DisagreeNot SureAgree Strongly Agree

10. Only people who are clinically stable should be involved in making decisions about their care.
Strongly Disagree DisagreeNot SureAgree Strongly Agree

11. Recovery is not as relevant for those who are actively psychotic or abusing substances.
Strongly Disagree DisagreeNot SureAgree Strongly Agree

12. Defining who one is, apart from his or her illness/condition, is an essential component of recovery.
Strongly Disagree DisagreeNot SureAgree Strongly Agree

13. It is often harmful to have too high of expectations for clients.
Strongly Disagree DisagreeNot SureAgree Strongly Agree

14. There is little that a professional can do to help a person recover if he/she is not ready to accept his/her illness/condition or need for treatment.
Strongly Disagree DisagreeNot SureAgree Strongly Agree

15. Recovery is characterized by a person making gradual steps forward without major steps back.
Strongly Disagree DisagreeNot SureAgree Strongly Agree

16. Symptom reduction is an essential component of recovery.
Strongly Disagree DisagreeNot SureAgree Strongly Agree

17. Expectations and hope for recovery should be adjusted according to the severity of the person's illness/condition.
Strongly Disagree DisagreeNot SureAgree Strongly Agree

18. The idea of recovery is most relevant for those people who have completed, or are close to completing, active treatment.
Strongly Disagree DisagreeNot SureAgree Strongly Agree

19. The more a person complies with treatment, the more likely he/she is to recover.
Strongly Disagree DisagreeNot SureAgree Strongly Agree

20. Other people who have a serious mental illness or who are recovering from substance abuse can be as instrumental to a person's recovery as mental health professionals.
Strongly Disagree DisagreeNot SureAgree Strongly Agree

1. **Section C Information about your hospital**

1. What hospital practices **most hinder** persons making progress on the road to recovery?

2. What hospital practices **most help** persons make progress on the road to recovery?

3. What in your opinion is the highest priority for improving care at this facility?

4. What do you think is your supervisor's highest priority for improving care at this facility?

5. What do you think is the facility's executive team's highest priority for improving care at this facility?

6. Activities and discussions at my team meetings assist me in understanding my role and responsibilities in helping persons make progress on the road to recovery at this hospital. Please circle the choice that best describes your experience:
Strongly Disagree DisagreeNot SureAgree Strongly Agree

7. What is your unique role in helping persons make progress on the road to recovery at this hospital?

Staff Interview:

	Q1				Q2				Q3			
	recovery relevant in all phases of treatment				unlikely to be able to decide goals				encourage risks in treatment			
Facility	Strongly Disagree	Disagree	Agree	Strongly Agree	Strongly Disagree	Disagree	Agree	Strongly Agree	Strongly Disagree	Disagree	Agree	Strongly Agree
All Eight MH Facilities Combined %	5	4	43	48	36	53	9	2	8	15	54	23
Catawba	4	5	48	38	39	46	7	2	4	14	38	14
CSH	6	0	40	42	34	49	7	1	8	11	45	12
ESH	3	7	40	37	27	51	9	4	5	12	39	18
NVMHI	7	2	20	70	46	46	7	2	7	11	43	22
PGH	3	7	33	50	32	50	10	2	2	7	40	27
SVMHI	6	2	40	49	32	55	4	2	4	11	43	15
SWVMHI	6	1	44	42	35	49	10	4	8	11	43	15
WSH	2	2	46	45	35	54	10	0	8	15	44	18
N (Total Responses)	537				548				447			

	Q4				Q5				Q6			
	symptom management 1st step in recovery				not everyone capable of participating in recovery				don't burden with responsibilities of everyday life			
Facility	Strongly Disagree	Disagree	Agree	Strongly Agree	Strongly Disagree	Disagree	Agree	Strongly Agree	Strongly Disagree	Disagree	Agree	Strongly Agree
All Eight MH Facilities Combined %	3	15	65	17	14	36	42	8	44	54	2	0
Catawba	4	25	46	11	18	36	39	0	45	54	2	0
CSH	4	2	63	16	12	34	34	6	37	57	0	1
ESH	1	15	65	10	7	29	49	10	44	48	4	0
NVMHI	0	24	48	22	33	26	35	2	57	37	2	0
PGH	7	18	43	17	12	30	38	8	40	55	2	0
SVMHI	4	11	62	15	15	43	25	6	40	60	0	0
SWVMHI	0	14	57	18	13	32	44	11	43	56	1	0
WSH	4	6	67	17	10	43	36	7	46	52	1	0
N (Total Responses)	519				542				569			

	Q7				Q8				Q9			
	recovery follows prescribed set of procedures				hobbies and leisure important to recovery				protect clients from failure and disappointments			
Facility	Strongly Disagree	Disagree	Agree	Strongly Agree	Strongly Disagree	Disagree	Agree	Strongly Agree	Strongly Disagree	Disagree	Agree	Strongly Agree
All Eight MH Facilities Combined %	17	44	33	6	1	2	44	53	14	59	21	5
Catawba	25	43	16	4	2	2	41	54	21	61	7	4
CSH	8	33	36	8	2	1	49	40	12	42	27	4
ESH	9	28	35	9	1	1	43	53	9	51	27	7
NVMHI	22	41	11	9	0	2	24	74	20	48	24	9
PGH	13	47	25	3	2	2	45	47	13	50	25	5
SVMHI	19	51	17	2	2	4	43	51	23	58	11	2
SWVMHI	14	47	28	4	1	1	44	50	6	75	11	6
WSH	18	31	40	0	0	2	44	53	13	62	17	4
N (Total Responses)	504				566				543			

	Q10				Q11				Q12			
	only stable people should make decisions				recovery not relevant for active SA				define self important to recovery			
Facility	Strongly Disagree	Disagree	Agree	Strongly Agree	Strongly Disagree	Disagree	Agree	Strongly Agree	Strongly Disagree	Disagree	Agree	Strongly Agree
All Eight MH Facilities Combined %	27	61	9	3	34	62	4	0	1	3	46	50
Catawba	30	59	4	2	46	48	4	0	0	2	30	61
CSH	25	53	12	1	27	59	2	0	0	2	54	33
ESH	21	54	13	2	29	61	6	0	2	2	51	39
NVMHI	39	43	13	0	48	46	2	0	0	2	24	67
PGH	27	62	2	3	25	67	0	0	0	5	32	48
SVMHI	19	70	8	2	21	64	6	0	0	0	49	47
SWVMHI	22	54	10	6	38	56	3	1	1	0	42	51
WSH	24	67	4	5	30	63	6	0	0	6	46	46
N (Total Responses)	545				551				542			

	Q13				Q14				Q15			
	harmful to have too high expectations				little can be done if person does not accept illness				recovery: gradual steps forward without steps backward			
Facility	Strongly Disagree	Disagree	Agree	Strongly Agree	Strongly Disagree	Disagree	Agree	Strongly Agree	Strongly Disagree	Disagree	Agree	Strongly Agree
All Eight MH Facilities Combined %	12	49	34	5	10	60	25	5	9	39	43	8
Catawba	9	45	25	4	14	61	13	4	16	55	23	2
CSH	8	33	37	2	6	41	34	5	2	30	49	7
ESH	8	41	29	5	6	50	27	7	5	30	46	9
NVMHI	13	41	24	7	24	48	15	2	24	35	26	13
PGH	8	48	23	3	5	62	22	2	5	42	33	8
SVMHI	17	47	23	0	11	58	23	4	9	32	40	8
SWVMHI	10	39	24	8	8	63	18	6	7	36	38	10
WSH	13	40	32	2	8	62	21	4	10	35	43	4
N (Total Responses)	486				531				530			

	Q16				Q17				Q18			
	symptom reduction is essential to recovery				expectations/hope should be adjusted based on severity				symptom reduction essential to recovery			
Facility	Strongly Disagree	Disagree	Agree	Strongly Agree	Strongly Disagree	Disagree	Agree	Strongly Agree	Strongly Disagree	Disagree	Agree	Strongly Agree
All Eight MH Facilities Combined %	1	9	75	15	4	27	57	11	21	57	19	3
Catawba	2	9	68	7	9	30	46	2	23	57	5	2
CSH	1	2	72	8	0	14	66	8	10	46	31	4
ESH	1	3	72	13	2	18	62	11	16	44	23	5
NVMHI	0	13	43	33	11	24	40	20	39	48	9	2
PGH	0	17	62	7	3	18	62	12	22	65	10	0
SVMHI	0	6	60	15	8	30	38	11	17	58	15	2
SWVMHI	1	7	65	17	6	36	43	11	18	58	14	4
WSH	0	11	68	13	1	35	52	10	20	57	21	1
N (Total Responses)	509				538				541			

	Q19				Q20			
	more compliance = more recovery				other individuals with MI can be helpful			
Facility	Strongly Disagree	Disagree	Agree	Strongly Agree	Strongly Disagree	Disagree	Agree	Strongly Agree
All Eight MH Facilities Combined %	2	15	61	22	2	4	56	39
Catawba	9	11	50	9	2	0	43	50
CSH	0	11	57	20	0	10	52	27
ESH	1	10	46	28	2	1	57	30
NVMHI	2	20	35	22	0	0	43	52
PGH	2	12	65	10	2	2	58	27
SVMHI	4	15	57	17	0	4	51	38
SWVMHI	0	18	54	15	3	6	47	35
WSH	0	11	57	21	2	4	52	38
N (Total Responses)	502				532			

Office of the Inspector General
for Mental Health, Mental Retardation, and Substance Abuse Services

Review of Services at Virginia State Mental Health Facilities

Treatment Team Observation Checklist

Name of Hospital: _____

Date: _____

Name of consumer being reviewed: (do one form for each person reviewed by the treatment team)
_____ **Please note comments, quotes, anecdotes freely.**

1. Was the consumer(s) present?
yes _____ no _____

2. If not, did the team discuss efforts to encourage or enable him/her to attend?
yes _____ no _____

3. Was there a family member, advocate, or other representative of the consumer present? If not, did the team discuss the consumer's need for assistance or representation?
yes _____ no _____

4. If there was a family member or other support person present, did they participate in a meaningful way? Did the team address them at appropriate times?
yes _____ no _____ not present ____

5. Was a direct service staff member who knows the consumer (from the unit or PSR) present?
yes _____ no _____

6. Was the CSB or other community resource present?
yes _____ no _____

7. Did the discussion relate to the actual goals in the plan (as opposed to recent behaviors, symptoms, medication issues)?
yes _____ no _____

8. Were the consumer's own goals discussed? Was the consumer asked about his goals?
yes _____ no _____

9. Did most members of the treatment team participate actively in discussions of each consumer – a true multi-disciplinary team? (If no, note main participants in order)
yes _____ no _____

10. Did the consumer have meaningful participation? Did the treatment team address the consumer at appropriate points and try to engage his or her participation?
yes _____ no _____ not present_____

11. Did the group use "people first" language? (see resource/guide)
yes _____ no _____

12. Did the discussion relate to the consumer in a holistic way? Could the observer sense that the treatment team were discussing a whole person, complete with a variety of strengths and weaknesses, spanning a variety of life areas, rather than a psychiatric "case," seen from the vantage point of various disciplines?

yes _____ no _____

13. Did the team talk about the importance of the consumer having a life at the facility that is filled adequately with activities and responsibilities that are appropriate for life outside the facility?

yes _____ no _____

14. Did they talk evaluatively with the consumer's participation about whether or not current daily activities at the hospital are fulfilling and growth producing, etc.?

yes _____ no _____

15. Was there any recognition or consideration of whether the consumer has key helping (healing) relationships or "circle of support" with anyone – staff, consumer, etc. - at the hospital or in the community?

yes _____ no _____

16. Was the discussion generally and foundationally related to "getting the person out of the hospital and back into a good life in the community," rather than just addressing ward behaviors, medication compliance, etc.?

yes _____ no _____

17. If discharge planning was discussed, did the planning reflect the consumer's choices and preferences? Was he/she asked?

yes _____ no _____ not applicable ____

18. If discharge planning was discussed, did the plans seem complete and supportive of a rich, multi-faceted experience (appropriate housing, work or day support, transportation, medical services, CSB support services, highest possible level of independence, etc.?)

yes _____ no _____ not applicable ____

19. Were the tone of the meeting or the majority of comments characterized by hope and positive expectations of recovery?

yes _____ no _____

20. Was there enough time available for a good discussion, to not feel rushed?

yes _____ no _____

21. Did doctor or other members of the team ask the person about how his medications were working, side effects, his satisfaction or preferences with medications?

yes _____ no _____

Treatment Team:

	Q1		Q2		Q3		Q4		Q5		Q6		Q7	
	individual present?		if not, discussed?		adv/family present?		did they participate?		DSA present?		CSB present?		discussion relate to goals?	
Facility	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No
All Eight MH Facilities Combined %	90	10	60	40	20	80	44	56	35	65	38	63	35	65
Catawba	56	44	22	22	0	100	0	22	22	78	100	0	0	89
CSH	100	0	0	0	0	100	0	0	100	0	67	33	0	100
ESH	100	0	0	0	50	50	0	17	0	100	0	100	17	67
NVMHI	100	0	33	0	33	67	33	0	100	0	33	67	100	0
PGH	100	0	0	0	67	33	33	0	33	67	0	100	100	0
SVMHI	100	0	0	0	25	75	25	25	0	100	13	88	50	38
SWVMHI	100	0	0	0	0	100	0	0	100	0	25	75	0	100
WSH	100	0	0	0	0	100	0	0	25	75	25	75	50	50
N (Total Responses)	40		5		40		9		40		40		37	

	Q8		Q9		Q10		Q11		Q12		Q13	
	individual's own goals discussed?		did most members participate?		consumer participate?		people first language?		holistic?		rich life in facility?	
Facility	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No
All Eight MH Facilities Combined %	49	51	75	25	94	6	38	62	59	41	32	68
Catawba	33	67	100	0	56	0	33	44	56	44	33	67
CSH	0	100	0	100	100	0	0	67	33	67	0	67
ESH	50	33	67	33	83	17	0	100	0	100	0	100
NVMHI	67	0	67	33	100	0	33	67	67	0	33	33
PGH	67	0	100	0	100	0	100	0	100	0	67	33
SVMHI	75	25	88	13	100	0	38	63	88	13	38	63
SWVMHI	0	100	25	75	75	25	25	75	50	50	25	75
WSH	50	50	100	0	100	0	75	25	75	25	50	50
N (Total Responses)	37		40		36		39		39		38	

	Q14		Q15		Q16		Q17		Q18	
	daily activities rewarding?		recognize helping/support relationship?		oriented to good life in community?		preferences for discharge?		full community planning?	
Facility	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No
All Eight MH Facilities Combined %	38	62	28	72	63	37	85	15	65	35
Catawba	33	44	0	100	22	56	33	11	11	11
CSH	0	67	0	67	67	33	0	33	0	33
ESH	0	100	0	100	33	67	33	17	0	50
NVMHI	33	67	33	67	100	0	100	0	67	0
PGH	100	0	33	67	67	33	67	0	67	0
SVMHI	38	63	50	50	100	0	88	0	75	13
SWVMHI	25	75	50	50	25	75	25	25	25	25
WSH	75	25	75	25	100	0	100	0	75	25
N (Total Responses)	37		39		38		26		23	

	Q19		Q20			Q21
	hope/recovery?		enough time?			MD ask about meds?
Facility	% Yes	% No	% Yes	% No	% Yes	% No
All Eight MH Facilities Combined %	66	34	83	18	71	29
Catawba	44	56	78	22	22	22
CSH	67	0	33	67	67	33
ESH	0	100	100	0	83	17
NVMHI	67	0	67	33	100	0
PGH	100	0	100	0	67	33
SVMHI	88	13	88	13	88	13
SWVMHI	75	25	75	25	50	50
WSH	100	0	100	0	50	50
N (Total Responses)	38		40		35	